Texas Medicaid Provider Enrollment Application

A STATE MEDICAID CONTRACTOR

Rev. XXXI

Introduction

Dear Health-care Professional:

Thank you for your interest in becoming a Texas Medicaid provider. Participation by providers in Texas Medicaid is vital to the successful delivery of Medicaid services, and we welcome your application for enrollment.

This application must be completed in its entirety as outlined in the instructions below and will be reviewed by the Texas Health and Human Services Commission (HHSC) and the claims contractor Texas Medicaid & Healthcare Partnership (TMHP).

Providers are encouraged to review the current *Texas Medicaid Provider Procedures Manual* for information about provider responsibilities, claims filing procedures, filing deadlines, benefits and limitations, and much more. The provider manual is updated monthly, and the current and archived provider manuals can be accessed on the TMHP web site at **www.tmhp.com**. Select "Reference Materials" from the Providers page.

There is no guarantee your application will be approved for processing or you will be assigned a Medicaid Texas Provider Identifier (TPI) number. If you make the decision to provide services to a Medicaid client prior to approval of the application, you do so with the understanding that, if the application is denied, claims will not be payable by Texas Medicaid, and the law also prohibits you from billing the Medicaid client for services rendered.

Privacy Statement

With a few exceptions, Texas privacy laws and the Public Information Act entitle you to ask about the information collected on this form, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the Texas Administrative Code, 1 TAC §351.17-§ 351.23.

For questions concerning this notice or to request information or corrections, please contact Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **1-800-925-9126**. TMHP customer service representatives are available Monday through Friday from 7 a.m. to 7 p.m. central standard time.

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the **physical address** listed on your application unless otherwise requested in the Contact Information section of this application.

Contact Information

For information about Medicaid provider identifier requirements, the status of your enrollment, or claims submission, call TMHP Contact Center toll-free at **1-800-925-9126**.

Thank you for your applying to become a Texas Medicaid provider.

Affordable Care Act

In compliance with the Affordable Care Act of 2010 (ACA), all providers are subject to ACA screening procedures for newly enrolling and re-enrolling providers. All participating providers must be screened upon submission of an application, including, but not limited to:

- Applications for providers that are new to Texas Medicaid.
- Applications for providers that are requesting new practice locations.
- Applications for currently enrolled providers that must periodically revalidate their enrollment in Texas Medicaid.

Refer to: Code of Federal Regulations (CFR) Title 42, Ch. IV, Part 455, Subpart E-Provider Screening and Enrollment; and Texas Administrative Code (TAC) Title 1, Part 15, Chapter 352, for the statutory provisions for these requirements.

Provider Screening

All providers are categorized by the Centers for Medicare & Medicaid (CMS)-defined risk levels of limited, moderate, and high based on an assessment of potential for fraud, waste, and abuse for each provider type. Providers will be screened according to their risk level and are subject to various screening activities for each risk level. Risk level assignments may be increased at any time at the discretion of HHSC. In these instances, the provider will be notified by HHSC, and the new risk level will apply to enrollment-related transactions.

Provider Revalidation

In compliance with ACA, all providers are required to revalidate their enrollment at least every three to five years depending on provider type. Providers will be notified that they are required to revalidate before their revalidation deadline. The ACA screening criteria applies during revalidation. Providers that do not revalidate their enrollment by the designated date will be disenrolled and will no longer receive reimbursement from Texas Medicaid.

Surety Bonds

DME suppliers are required to submit proof of a valid surety bond when submitting: 1) an initial enrollment application to enroll in Texas Medicaid, 2) an enrollment application to establish a new practice location, 3) an enrollment application for re-enrollment in Texas Medicaid.

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to the Department of State Health Services (DSHS).

The Surety Bond Form can be found on the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**.

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ALL PROVIDERS – Forms and Attachments

This Texas Medicaid Provider Enrollment Application can be completed to enroll in Texas Medicaid as a traditional Medicaid provider, a Texas Health Steps (THSteps) medical check-up provider, and a Children with Special Health Care Needs (CSHCN) Services Program provider. Upon completion of this application, qualified providers will automatically be enrolled as THSteps medical check-up providers and CSHCN Services Program providers unless they choose to opt out of one or both as prompted in this application.

If the provider chooses to opt out of THSteps or the CSHCN Services Program upon submission of this application, the following applications can be submitted at a later time to enroll in THSteps or the CSHCN Services Program:

- THSteps Provider Enrollment Application
- CSHCN Services Program Provider Enrollment Application

The following additional applications are available for enrollment in other Texas Medicaid programs and services and are not included in this Texas Medicaid Provider Enrollment Application:

- THSteps Dental (Enrollment will be considered with the submission of the THSteps Dental Provider Enrollment Application)
- Medical Transportation Program (MTP) (Enrollment will be considered with the submission of the Medical Transportation Program Meal Provider Enrollment Application, or the Medical Transportation Program Lodging Provider Enrollment Application)
- MTP – State (Transportation Service Area Providers [TSAPs] are contracted by HHSC through a procurement process. For more information, providers should contact HHSC at 1-877-633-8747.)
- Ordering/Referring Only (Enrollment will be considered with the submission of the Texas Medicaid Enrollment Application for Ordering and Referring Providers. This Ordering/Referring Provider Enrollment Application is for those individual providers who do not bill Texas Medicaid for rendered services, but who only order or refer supplies and services for Texas Medicaid or CSHCN Services Program Providers.)
- Texas Vaccines for Children Program (TVFC)

To complete this Texas Medicaid Provider Enrollment Application, the following forms must be completed and returned for processing:

- Application Payment Form (if applicable) (refer to the instructions for additional information) (p. xxvii)
- Medicare Enrollment Information Form (p. xxv)
- Texas Medicaid Identification Form (p. 1-1 through 1-3)
- Texas Medicaid Provider Enrollment Application (p. 2-1 through 2-3)
- Disclosure of Ownership and Control Interest Statement Form (performing providers and SHARS providers are exempt) (p. 2-5 through 2-7)
- Principal Information Form (PIF-2) (performing providers are exempt) (p. 2-8 through 2-13)
- Provider Information Form (PIF-1) (p. 2-15 through 2-20)
- HHSC Medicaid Provider Agreement (original signatures required) (p. 3-1 through 3-5)
- IRS W-9 Form (performing providers exempt) (p. 4-1 through 4-4)

If the enrolling provider is **incorporated**, the following additional forms must be completed and returned for processing:

- Corporate Board of Directors Resolution Form – MUST BE NOTARIZED. (original signatures required)
- For corporations formed prior to January 1, 2006: Articles or Certificate of Incorporation/Certificate of Authority/Certificate of Fact (required for in-state corporations; certificate can be obtained from the Office of Secretary of State)*

- For corporations formed on or after January 1, 2006: Certificates of Formation or Certificate of Filing *
- Franchise Tax Account Status Page (Refer to the instructions table for additional information.)*

Note: *For the items indicated with an asterisk (*), out-of-state providers that do not provide services in the state of Texas are exempt and do not have to submit these additional forms.*

The following attachments must be submitted with the enrollment application if applicable for the requested provider type:

- Medicare Approval letter or Medicare Remittance Advice Notices (MRAN) that is not older than four weeks from the application submitted date (**Important:** *If Medicare enrollment is required as a prerequisite for enrolling in Medicaid, your Medicaid enrollment could be delayed if this letter is not attached*)
- Copy of Certification of Mammography Systems from the Bureau of Radiation Control (BRC) (for all providers rendering mammography services)
- Copy of CLIA Certificate with approved specialty services as appropriate
- Medicaid Audit Information (facilities only)
- Texas Women's Health Program (TWHP) Certification (original signatures required)

Important: *Retain a copy for your records of all documents submitted for enrollment.*

OUT-OF-STATE PROVIDERS

Out-of-state providers are subject to a limited enrollment term. You must submit proof of meeting one of the following criteria prior to being able to enroll with Texas Medicaid:

- A medical emergency documented by the attending physician or other provider.
- The client's health is in danger if he or she is required to travel to Texas.
- Services are more readily available in the state where the client is temporarily located.
- The customary or general practice for clients in a particular locality is to use medical resources in the other state (this is limited to providers located in a state bordering Texas).
- All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency).
- The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.
- The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid)
- The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.
- The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:
    - Texas Medicaid enrolled providers rely on the services provided by the applicant.
    - Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
- A laboratory may participate as an in-state provider, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:
    - The laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;

- The laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and
- The laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefit programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.

Refer to: The current *Texas Medicaid Provider Procedures Manual* at www.tmhp.com for further information.

PERFORMING PROVIDERS

If the performing provider is the applicant, and the applicant is enrolling in Texas Medicaid to be added to an **existing group**, the applicant must complete the following Texas Medicaid Provider Enrollment Application forms:

- Medicare Enrollment Information
- Section A. Provider of Service Information
- Section D. Provider Information Form (PIF-1)
- HHSC Medicaid Provider Agreement (original signature required)

If the group is the applicant, each performing provider that is listed in Section C of this application must also complete a PIF-1 and an HHSC Medicaid Provider Agreement. All completed forms must be submitted with the group's Texas Medicaid Provider Enrollment Application.

INSTRUCTIONS – Completing the Application and Additional Forms

Complete the Texas Medicaid Provider Enrollment Application using the following information:

Item	Instructions
Application Payment Form	Certain providers are required to submit the application fee. This application cannot be processed if the application fee is required and is not submitted with the application. **Refer to the TMHP Affordable Care Act website at www.tmhp.com to determine if you are required to pay the application fee.**
Medicare Enrollment Information	REQUIRED: Medicare enrollment is a prerequisite for Medicaid enrollment if you render services for clients who are eligible for Medicare. If you have a Medicare number that pertains to this enrollment, you must supply the number to TMHP. If you do not have a Medicare number and are eligible to request a waiver, check the box for the waiver request that matches your situation. ***This information is required. Your enrollment in Texas Medicaid may be delayed if this section of the application is not completed at the time of submission.***
Type of Enrollment:	Choose the appropriate box to indicate if this is a new enrollment for a new provider, new provider type, new practice location, etc. or if this enrollment is in response to a re-enrollment letter.
Requesting Enrollment as:	Choose one as defined below: **Individual enrollment.** This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or tax identification number of the individual. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including dieticians, licensed vocational nurses (LVN), occupational therapists, and speech therapists.

Item	Instructions
Requesting Enrollment as: (*cont.*)	**Group enrollment.** This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and tax identification number of the legal entity. For any group enrollment application, there must also be at least one enrolling performing provider. • If enrolling as a single-specialty group, choose "Group" and choose the appropriate specialty in the Provider Identification Form section. • If enrolling as a multi-specialty group, choose "Group" and choose "Multi-specialty" in the Provider Identification From section. **Important:** *If you do not choose "Multi-specialty" in the Provider Identification Form, you will be enrolled as a single-specialty group.* **Performing Provider enrollment.** This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the tax identification number of the group, and payment is made to the group. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the tax identification number of their employer. **Facility enrollment.** This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers.
List NPI	Enter your National Provider Identifier (NPI) in this box. An NPI is not required for Financial Management Services Agency (FMSA), Milk Donor Bank, Personal Assistance Services, and Service Responsibility Option (SRO) providers.
Additional Enrollment	Upon completion of this application, you will automatically be enrolled in the CSHCN Services Program unless you opt out of CSHCN Services Program enrollment. Check the box if you are *opting out* of CSHCN Services Program enrollment. If you check this box, you will only be considered for enrollment in Texas Medicaid. **Note:** *If you do not check this box indicating that you would like to be considered for enrollment in the CSHCN Services Program, also complete the following forms that are available for download at www.tmhp.com:* • CSHCN Services Program Identification Form • Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program • Required Information for Customized Durable Medical Equipment (DME) Providers (as applicable) • Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider (as applicable)

Item	Instructions
Texas Medicaid Identification Form – Traditional Services *Texas Medicaid services are categorized by traditional services, case management services, and Comprehensive Care Program (CCP) services. Check the box with the appropriate category that identifies the provider type with which you are seeking enrollment. Check only the appropriate box to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to the instructions.*	
Traditional Services	**Anesthesiologist Assistant (AA).** To enroll in Texas Medicaid, AA providers must enroll as performing providers into an anesthesiology group, a multi-specialty group or a state hospital physician group only. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required. Certification information will be required upon enrollment.
Traditional Services	**Ambulance/ Air Ambulance.** To enroll in Texas Medicaid, ambulance providers must: 1) operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; 2) equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; 3) acquire a license from Texas Department of State Health Services (DSHS) approving equipment and training levels of the crew; 4) enroll in Medicare. A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance TPI, not the hospital TPI. You must attach a copy of your permit/license. In addition, ambulance providers must disclose the Medical Director (a physician who is actively licensed by the Texas Medical Board). A PIF-2 will be required of the Medical Director. Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to the Department of State Health Services (DSHS).
Traditional Services	**Ambulatory Surgical Center (ASC).** To enroll in Texas Medicaid, ASCs must: meet and comply with applicable state and federal laws and provisions of the state plan under Title XIX of the Social Security Act for Medical Assistance, and be enrolled in Medicare. Out-of-state ASCs that are Medicare-certified as an ASC in the state where they are located and provide services to a Texas Medicaid client may be entitled to participate in Texas Medicaid.
Traditional Services	**Audiologist.** To enroll in Texas Medicaid, audiologists must be licensed by the licensing board of their profession to practice in the state where the services were performed and be enrolled as a Medicare provider. Audiologists must also be currently certified by the American Speech, Language, and Hearing Association or meet the Association's equivalency requirements. Audiologists can enroll as groups or into multi-specialty groups. Medicare enrollment is a prerequisite for enrollment as a Medicaid group. **Refer to:** "Hearing Aid" for enrollment requirements for Hearing aid fitter/dispenser providers (a separate application must be submitted).

Item	Instructions
Traditional Services	**Birthing Center.** To enroll in Texas Medicaid, a birthing center must be licensed by DSHS. Texas Medicaid only reimburses birthing center services that provide a level of service equal to the professional skills of a physician, certified nurse-midwife (CNM), or licensed midwife (LM) who acts as the birth attendant. A birthing center is defined as a facility or institution where a woman is scheduled to give birth following an uncomplicated (low-risk) pregnancy. This term does not include a hospital, ambulatory surgical center, nursing facility, or residence of the woman giving birth. You must attach a copy of your license.
Traditional Services	**Catheterization Lab.** To enroll in Texas Medicaid, a catheterization lab must be Medicare-certified.
Traditional Services	**Certified Nurse Midwife (CNM).** To enroll in Texas Medicaid, a CNM must be a licensed registered nurse who is recognized by the Texas Board of Nursing as an advanced practice nurse in nurse-midwifery and certified by the American College of Nurse-Midwives. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. CNMs must complete the Physician Letter of Agreement form for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers and submit the agreement with this enrollment application.
Traditional Services	**Certified Registered Nurse Anesthetist (CRNA).** To enroll in Texas Medicaid, a CRNA must be a registered nurse approved as an advanced practice nurse by the state in which they practice and be currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider. CRNAs can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required. You must attach a copy of your CRNA certification or re–certification card.
Traditional Services	**Chemical Dependency Treatment Facility.** Chemical dependency treatment facilities licensed by DSHS are eligible to enroll in Texas Medicaid. Chemical dependency treatment facility services are those facility services determined by a qualified credentialed professional, as defined by the DSHS Chemical Dependency Treatment Facility Licensure Standards, to be reasonable and necessary for the care of clients of any age. You must attach a copy of your license.
Traditional Services	**Chiropractor.** To enroll in Texas Medicaid, a doctor of chiropractic (DC) medicine must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider. Chiropractors can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.
Traditional Services	**Community Mental Health Center –** To enroll in Texas Medicaid, the provider must be actively enrolled in Medicare.
Traditional Services	**Comprehensive Health Center (CHC).** To enroll in Texas Medicaid to provide medical services, physicians (MD and DO) and doctors (DMD, DDS, OD, DPM, and DC) must be licensed by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided. All physicians except pediatricians and physicians doing only THSteps medical screens must be enrolled in Medicare before Medicaid enrollment. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

Item	Instructions
Traditional Services	**Comprehensive Outpatient Rehab Facility (CORF).** To enroll in Texas Medicaid, a CORF must be Medicare-certified. CORFs are public or private institutions primarily engaged in providing, under medical direction, diagnostic, therapeutic, and restorative services to outpatients, and are required to meet specified conditions of participation.
Traditional Services	**Dentist/Doctor of Dentistry as a Limited Physician.** Dentists can enroll as traditional Medicaid providers to be reimbursed for medically necessary dental services, and as THSteps dental providers to be reimbursed for preventive dental care for THSteps dental clients. To enroll as a Doctor of Dentistry Practicing as a Limited Physician, a dentist must be currently licensed by the TSBDE or currently be licensed in the state where the service was performed at that time, have a Medicare provider identification number before applying for and receiving a Medicaid provider identifier and enroll as a Medicaid provider with a limited physician provider identifier using the Traditional Medicaid Provider Enrollment Application. Dentists must complete an enrollment application for each separate practice location and will receive a unique nine-digit Medicaid provider identification number for each practice location. Dentists can enroll as individuals, dentist groups, or multi-specialty groups. The owner of the group must be a licensed dentist. ***Note:*** *The Texas Medicaid Provider Enrollment Application is required to enroll in Texas Medicaid as a Doctor of Dentistry as a Limited Physician. To enroll in Texas Medicaid as a THSteps dental provider, complete and submit the Texas Health Steps (THSteps) Dental Provider Enrollment Application.*
Traditional Services	**Durable Medical Equipment (DME)/Durable Medical Equipment-Home Health (DMEH).** Providers of DME must be enrolled in Medicare (Palmetto). Enrolled providers of DME or expendable medical supplies are issued a DMEH TPI that is specific to home health services. Providers of customized and non-basic medical equipment are also enrolled as a DME provider. Prescriptions and diabetic syringes are covered through the Medicaid Vendor Drug Program. Refer to the Pharmacy section for more information on pharmacies enrolled as CCP providers. DME providers must purchase a surety bond as a condition of enrollment in Texas Medicaid. The State of Texas Medicaid Provider Surety Bond Form must be submitted with this application.
Traditional Services	**Family Planning Agency.** Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. To enroll in Texas Medicaid, family planning agencies must ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician and have a medical director who is a physician currently licensed to practice medicine in Texas. Agencies must have an established record of performance in the provision of both medical and educational/counseling family planning services as verified through client records, established clinic hours, and clinic site locations; provide family planning services in accordance with DSHS standards of client care for family planning agencies; and be approved for family planning services by the DSHS Family Planning Program. Physicians who wish to provide Medicaid Obstetric and Gynecologic (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only TPI for OB-GYN services regardless of provider specialty. Similarly, federally qualified health centers do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC TPI using family planning procedure codes.

Item	Instructions
Traditional Services	**Federally Qualified Health Center/Federally Qualified Satellite/Federally Qualified Look-Alike**. To enroll in Texas Medicaid, a Federally Qualified Health Center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. FQHC "look-alikes" are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers. A copy of the Public Health Service issued notice of grant award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to the TMHP Provider Enrollment Department annually. Centers are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual **physical addresses**. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service–approved satellites using an Federally Qualified Satellite (FQS) TPI that ties back to the parent FQHC TPI and Federal Tax ID. This procedure allows for the parent FQHC to have one provider agreement as well as one cost report combining all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill Texas Medicaid directly, the center must have a separate TPI from the parent FQHC and will be required to file a separate cost report. You must attach a copy of your grant award and the Federally Qualified Health Center Affiliation Affidavit. The form may be downloaded from the TMHP website at www.tmhp.com.
Traditional Services	**Freestanding Psychiatric Facility.** To be eligible to participate in CCP, a psychiatric hospital/facility must be accredited by the Joint Commission, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet the Joint Commission accreditation requirements. Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients ages 21-64.
Traditional Services	**Freestanding Rehabilitation Facility.** To be eligible to participate in CCP, a freestanding rehabilitation hospital must be certified by Medicare, have a valid Provider Agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding rehabilitation hospitals for CCP services and Medicare deductible/coinsurance. The information in this section is applicable to CCP services only.
Traditional Services	**Genetics.** Only full-service genetic providers may enroll in Texas Medicaid. Before enrolling, the provider must contract with DSHS for the provision of genetic services. Basic contract requirements are as follows. 1) The provider's medical director must be a clinical geneticist (MD or DO) who is board eligible/certified by the American Board of Medical Geneticists (ABMG). The physician must oversee the delivery and content of all medical services. 2) The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of at least the following professional staff. 3) The clinical geneticist (MD or DO) and at least one of the following: nurse, genetic associate, social worker, medical geneticist, or genetic counselor. Administrative personnel and support staff may also be involved. Additionally, each genetic professional providing clinical services must obtain a performing TPI from TMHP. For more contracting information, contact: DSHS Genetic Screening and Case Management Division, 1100 West 49th Street, Austin TX 78756-3199, 512-458-7111 X2193.

Item	Instructions
Traditional Services	**HCSSA.** Home and Community Support Services Agency (HCSSA). An entity licensed by DADS that provides home care, hospice, or personal assistance services for pay or other consideration in a client's residence, an independent living environment, or another appropriate location. Refer to the Home Health section of this instruction table for additional information about HCSSA enrollment for home health agencies.
Traditional Services	**Hearing Aid.** To enroll in Texas Medicaid, hearing professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service was performed. Additionally, audiologists must also be currently certified by the American Speech, Language, and Hearing Association or meet the Association's equivalency requirements. Audiologists do not have to provide separate licensure to enroll as a fitter and dispenser because the audiology licensure encompasses and constitutes registration to fit and dispense hearing instruments. **Note:** *An audiologist must provide a separate application to enroll as an audiologist.*
Traditional Services	**Home Health.** Home health services (e.g., intermittent skilled nursing, physical therapy, occupational therapy and home health aide) are provided under Texas Medicaid as Title XIX services. To enroll, a provider must be a licensed HCSSA that is also Medicare certified. These facilities will have the Licensed and Certified Home Health (LCHH) category listed on the DADS issued license. Home health providers may render traditional Title XIX Medicaid home health services, telemonitoring services, and CCP services. **Licensed Home Health-CCP.** Licensed Home and Community Support Services Agencies (HCSSA) that are not Medicare certified, but have the licensed home health category on their DADS issued license may provide only Private Duty Nursing, CCP therapy to children (0-20), telemonitoring services, or Personal Care Services (PCS) under Texas Medicaid Comprehensive Care Program. HCSSAs that also wish to provide Title XIX, Medicaid home health services must also be Medicare certified. **Note:** *Home health providers with a category of service of hospice are not enrolled in Texas Medicaid.*
Traditional Services	**Hospital – In State.** To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.
Traditional Services	**Hospital Ambulatory Surgical Center (HASC).** Hospitals certified and enrolled in Texas Medicaid are assigned a nine-character TPI (HASC) exclusively for billing day surgeries.
Traditional Services	**Hospital – Military.** To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veteran's Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.
Traditional Services	**Hospital –Out of State.** To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

Item	Instructions
Traditional Services	**Hyperalimentation.** To enroll in Texas Medicaid, providers of in-home total parental parenteral nutrition must be enrolled in Medicare (Palmetto) as in-home total parental hyperalimentation supplier providers.
Traditional Services	**Independent Diagnostic Testing Facility (IDTF).** To enroll in Texas Medicaid, an IDTF provider must be actively enrolled in Medicare.
Traditional Services	**Independent Laboratory (No Physician involvement/Physician involvement).** To enroll in Texas Medicaid, the independent (freestanding) laboratory must: 1) be independent from a physician's office or hospital; 2) meet staff, equipment, and testing capability standards for certification by HHSC; and 3) have Medicare certification.
Traditional Services	**Licensed Marriage Family Therapist (LMFT).** To enroll in Texas Medicaid, whether as an individual or as part of a group, an LMFT must be licensed by the Texas State Board of Examiners of Marriage and Family Therapists. LMFTs are covered as Medicaid-only providers. Therefore, enrollment in Medicare is not a requirement. LMFTs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Texas Medicaid.
Traditional Services	**Licensed Midwife (LM).** To enroll in Texas Medicaid, an LM must be licensed and approved by the Texas Midwifery Board under Chapter 203 of the Occupations Code and 22 TAC Chapter 831 (relating to Midwifery). Per the Affordable Care Act, Section 2301, LMs are able to perform certain professional services in birthing centers, given they are licensed birthing attendants as recognized by Texas. LMs are required to retain a referring/consulting physician as a condition of enrollment. LMs can enroll as individuals, performing providers, or single specialty groups. LMs are not recognized by Medicare and are not required to enroll in Medicare as a prerequisite for Medicaid enrollment. LMs must complete the Physician Letter of Agreement form for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers and submit the agreement with this enrollment application.
Traditional Services	**Licensed Professional Counselor (LPC).** To enroll in Texas Medicaid, independently or as a group of practicing LPCs, you must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement for enrollment in Medicaid. Practitioners holding a temporary license are not eligible to enroll in Medicaid. LPCs can enroll as groups or into multi-specialty and Behavioral Health groups. The Provider Agreement, Provider Information Form (PIF-1) and, Principal Information Form (PIF-2) must be complete for the group and each performing provider enrolling into the group.

Item	Instructions
Traditional Services	**Maternity Service Clinic (MSC).** To enroll in Texas Medicaid, maternity service clinics (MSC) must ensure that the physician prescribing the services is employed by or has a contractual agreement/formal arrangement with the clinic to assume professional responsibility for the services provided to clinic patients. To meet this requirement a physician must see the patient at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care. Medicare certification is not a prerequisite for MSC enrollment. An MSC must: 1) be a facility that is not an administrative, organizational, or financial part of a hospital; 2) be organized and operated to provide maternity services to outpatients; 3) comply with all applicable federal, state, and local laws and regulations; 4) an MSC wanting to bill and receive reimbursement for case management services to high-risk pregnant adolescents, women, and infants must meet the criteria specified in the Case Management for Children and Pregnant Women section.
Traditional Services	**Multi-Specialty Group.** Physicians and behavioral health providers can enroll in Texas Medicaid as multi-specialty groups. All providers enrolled in the group must be actively enrolled in Medicare and must enroll in Texas Medicaid as part of the multi-specialty group. All providers must be licensed as Physicians by the Texas Medical Board or by the appropriate state board where services are rendered.
Traditional Services	**Nurse Practitioner/Clinical Nurse Specialist (NP/CNS).** To enroll in Texas Medicaid, NP and CNS providers must be licensed as a registered nurse and be approved as an NP/CNS by the Texas Board of Nursing. All NP/CNS providers are enrolled within the categories of practice as determined by the Texas Board of Nursing. NP/CNS providers can enroll as groups or into multispecialty groups. If enrolling into a Medicare-enrolled multispecialty group, Medicare enrollment is required.
Traditional Services	**Occupational Therapist (OT).** To enroll in Texas Medicaid, the provider must be licensed as an Occupational Therapist by the Executive Council of Physical Therapy & Occupational Therapy Examiners or by the appropriate state board where services are rendered. The provider must be actively enrolled in Medicare as an occupational therapist. Occupational therapists are also eligible to enroll in CCP. Refer to the Occupational Therapist-CCP section of this instructions table for additional information.
Traditional Services	**Optician.** To enroll in Texas Medicaid, opticians must be enrolled as Medicare Providers. Opticians can enroll as groups or into multispecialty groups.
Traditional Services	**Optometrist (OD).** To enroll in Texas Medicaid, doctors of optometry (OD) must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare Providers. Optometrists can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.
Traditional Services	**Orthotist.** Orthotists must be enrolled in Medicare and licensed by the Texas Board of Orthotics and Prosthetics as a licensed orthotist (LO) or licensed prosthetist/orthotist (LPO) to measure, design, fabricate, assemble, fit, adjust, or service an orthosis for the correction or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity.
Traditional Services	**Outpatient Rehabilitation Facility (ORF).** To enroll in Texas Medicaid, an ORF must be Medicare-certified. ORFs are public or private institutions primarily engaged in providing, under medical direction, diagnostic, therapeutic, and restorative services to outpatients, and are required to meet specified conditions of participation.

Item	Instructions
Traditional Services	**Personal Assistant Services/PCS.** Providers that want to participate in the delivery of PCS must have one of the following Texas Department of Aging and Disability Services (DADS) licensures: • Personal assistance services (PAS) • Licensed home health services (LHHS) • Licensed and certified home health services (LCHHS) Licensed Home and Community Support Services Agencies (HCSSA) that are not Medicare certified may provide ONLY Personal Care Services (PCS) under Texas Medicaid CCP.
Traditional Services	**Pharmacy Group** - A pharmacy is a facility used by pharmacists for the compounding and dispensing of medicinal preparations and other associated professional and administrative services. A pharmacy is a facility whose primary function is to store, prepare and legally dispense prescription drugs under the professional supervision of a licensed pharmacist. It meets any licensing or certification standards set forth by the jurisdiction where it is located. Pharmacies must complete an application as a "group" if interested in providing Medicaid clients only vaccines. As a "group" applicant, at least one performing provider application must be submitted as a pharmacist. Pharmacies must be certified by Medicare. Pharmacies must complete the application as a "facility" if interested in providing DME and supplies to all Medicaid clients. Each pharmacy must be certified by Medicare.
Traditional Services	**Pharmacist.** A pharmacist is an individual licensed by the appropriate state regulatory agency to engage in the practice of pharmacy. The practice of pharmacy includes, but is not limited to: assessment, interpretation, evaluation and implementation, initiation, monitoring or modification of medication and or medical orders; the compounding or dispensing of medication and or medical orders; participation in drug and device procurement, storage, and selection; drug administration; drug regimen reviews; drug or drug-related research; provision of patient education and the provision of those acts or services necessary to provide medication therapy management services in all areas of patient care. Pharmacists must complete an application as an "individual" or "performing provider" under a pharmacy "group" if interested in providing Medicaid clients only vaccines. Pharmacists must be certified by Medicare and certified to perform immunizations
Traditional Services	**Physical Therapist (PT).** To enroll in Texas Medicaid, independently practicing licensed physical therapists must be enrolled in Medicare. If you are currently enrolled with Texas Medicaid or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in CCP is not necessary. All non-CCP physical therapy services must be billed with your current Medicaid TPI.
Traditional Services	**Physician.** To enroll in Texas Medicaid to provide medical services, physicians (MD and DO) and doctors (DMD, DDS, OD, DPM, and DC) must be licensed by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided. All physicians (except pediatricians, OB-GYNs, and physicians doing only THSteps medical checkups) must be enrolled in Medicare before Medicaid enrollment. TMHP may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare. Physicians can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.

Item	Instructions
Traditional Services	**Physician Assistant (PA).** To enroll in Texas Medicaid, a PA must be licensed as a PA and be recognized as a PA by the Texas Physician Assistant Board. All PAs are enrolled within the categories of practice as determined by the Texas Medicaid Board. PAs can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.
Traditional Services	**Physiological Lab.** To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.
Traditional Services	**Podiatrist.** Podiatrists (DPM) must be Medicare-certified and enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their licensure as a DPM when such procedures would also be reimbursable to a physician (MD or DO) under Texas Medicaid. Podiatrist can enroll as groups or into multi-specialty groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.
Traditional Services	**Portable X-Ray.** To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. A physician must direct both radiological and physiological laboratories.
Traditional Services	**Prosthetist.** Prosthetists must be enrolled in Medicare and licensed by the Texas Board of Orthotics and Prosthetics as a prosthetist (LP) or prosthetist/orthotist (LPO) to measure, design, fabricate, assemble, fit, adjust, or service a prosthesis.
Traditional Services	**Prosthetist/Orthotist –** To enroll as a prosthetist/orthotist, you must be licensed as both. Refer to the Prosthetist and Orthotist sections of these instructions for additional information.
Traditional Services	**Psychologist.** To enroll in Texas Medicaid, an independently practicing psychologist must be licensed by the Texas State Board of Examiners of Psychologists and be enrolled as a Medicare provider. Psychologists can enroll as groups or into multi-specialty groups. A copy of the psychologist's license that is not due to expire within 30 days must be submitted with this application.
Traditional Services	**Qualified Rehabilitation Professional (QRP).** A person who meets one or more of the following criteria: a) Holds a certification as an assistive technology professional or a rehabilitation engineering technologist issued by, and in good standing with, the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA); b) Holds a certification as a seating and mobility specialist issued by, and in good standing with, RESNA; and/or c) Holds a certification as a certified rehabilitation technology supplier issued by, and in good standing with, the National Registry of Rehabilitation Technology Suppliers (NRRTS). A copy of the NRRTS/RESNA certification must be submitted with this application.
Traditional Services	**Radiation Treatment Center.** To enroll in Texas Medicaid, Radiation Treatment Centers must be Medicare-certified and certified by HHSC Bureau of Radiation Control.
Traditional Services	**Radiological Lab.** To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. A physician must direct both radiological and physiological laboratories.

Item	Instructions
Traditional Services	**Renal Dialysis Facility.** To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state that it is located to provide services. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.
Traditional Services	**Respiratory Care Practitioner (CRCP).** To enroll in Texas Medicaid, a certified respiratory care practitioner (CRCP) must be certified by HHSC to practice under Texas Civil Statutes, Article 4512L. As of January 1, 1988, the National Board for Respiratory Care Exam must be passed to be certified by HHSC. Medicare certification is not a prerequisite for Medicaid enrollment.
Traditional Services	**Rural Health Clinic - Hospital, Freestanding.** Medicare is required for enrollment as a Title XIX Rural Health Clinic (RHC).
Traditional Services	**Skilled Nursing Facility.** To enroll in Texas Medicaid, the provider must be licensed as a nursing facility by DADS or by the appropriate state board where services are rendered. The provider must be actively enrolled in Medicare as a skilled nursing facility.
Traditional Services	**Social Worker (LCSW).** To enroll in Texas Medicaid independently or as a group, a licensed clinical social worker (LCSW) must be licensed through the Texas State Board of Social Work Examiners as a LCSW and be enrolled in Medicare or obtain a pediatric practice exemption through TMHP Provider Enrollment. Practitioners holding a temporary license are not eligible to enroll in Medicaid. Social Workers can enroll as groups or into multi-specialty or behavioral health groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.
Traditional Services	**SHARS – School, Co-op, or School-Based Health Center.** To enroll in Texas Medicaid, school-based health centers, including charter schools, must employ, or contract with, individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS in order to bill and be reimbursed for program services. (See Texas Medicaid Provider Procedures Manual, School Health and Related Services.)
Traditional Services	**Specialized/Custom Wheeled Mobility - CCP (20 and younger).** A provider supplying items of durable medical equipment that are powered or manual mobility systems, including seated positioning components, powered or manual seating options, electronic drive control, specialty driving controls, multiple adjustment frame, nonstandard optimizations, and other complex or specialized components for clients who are 20 years of age and younger.
Traditional Services	**Specialized/Custom Wheeled Mobility - Home Health (all ages).** A provider supplying items of durable medical equipment that are powered or manual mobility systems, including seated positioning components, powered or manual seating options, electronic drive control, specialty driving controls, multiple adjustment frame, nonstandard optimizations, and other complex or specialized components. NOTE: If you are enrolling as a Specialized/Custom Wheeled Mobility provider and you also supply other types of Durable Medical Equipment, then you will need to include your Palmetto Number and Taxonomy Code in the application.

Item	Instructions
Traditional Services	**TB Clinic.** To enroll in Texas Medicaid, the tuberculosis (TB) clinic must be: 1) A public entity operating under Department of State Health Services (DSHS) Infectious Disease Control Unit Tuberculosis Program (IDCU/TB) tax identification number (TB regional clinic) or 1) A public entity operating under a non-Department of State Health Services (DSHS) Infectious Disease Control Unit Tuberculosis Program (IDCU/TB) tax identification number (city/county/local clinic) or 1) A non-hospital based entity for private providers and 2) A provider of TB-related clinic services must apply to the Department of State Health Services (DSHS) Infectious Disease Control Unit Tuberculosis Program (IDCU/TB) Tuberculosis Elimination Division. For more information about provider qualifications, contact the Tuberculosis Elimination Division, Financial Services and Medicaid Unit at 512-458-7447. To receive a provider application form or provider supplement, send a request to the following address: Tuberculosis Elimination Division, ATTN: Financial Services and Medicaid Unit, 1100 West 49th Street, Austin TX 78756-3199.
Traditional Services	**Vision Medical Supplier (VMS).** To enroll in Texas Medicaid, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare (Palmetto) Providers.
Texas Medicaid Identification Form – Case Management Services	
Case Management Services	**Blind Children's Vocational Discovery & Development Program.** The Texas Commission for the Blind (TCB) is eligible to enroll as a Medicaid provider of case management for blind and visually impaired clients (BVIC) younger than age 16.
Case Management Services	**Case Management for Children and Pregnant Women/ Targeted Case Management (PWI)/THSteps Medical Case Management Services.** Enrollment for Case Management for Children and Pregnant Women is a two-step process. Potential providers must submit a Texas Department of State Health Services (DSHS) Case Management for Children and Pregnant Woman application to the DSHS Health Screening and Case Management Unit. Upon approval by DSHS potential providers must enroll as a Medicaid provider for Case Management for Children and Pregnant Women. After the enrollment process is completed, the applicant is notified, in writing, of the provider status and TPI. The facility must enroll as a group and enroll registered nurses and social workers as performing providers of the group. The Provider Agreement, Provider Information Form (PIF-1) and Principal Information Form (PIF-2) must be completed for each principal of the group and each performing provider enrolling into the group. You must attach a copy of your approval letter from the Department of State Health Services (DSHS) if you are enrolling as a new group or individual. Note: THSteps Medical Case Management (MCM) and Targeted Case Management for High Risk Pregnant Women and High Risk Infants (PWI) Programs are combined with the Case Management for Children and Pregnant Women (CPW) Program.
Case Management Services	**Early Childhood Intervention (ECI).** To participate in Texas Medicaid, an ECI provider must comply with all applicable federal, state, local laws, and regulations about the services provided. Contractors must be certified by the Texas ECI program and must submit a copy of the current contract award from the Texas ECI program. You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention.

Item	Instructions
Case Management Services	**Home and Community Based Service - Adult Mental Health (HCBS-AMH).** To enroll in Texas Medicaid, a HCBS-AMH provider must be approved by DSHS. HCBS-AMH providers must enroll as a facility and are not required to enroll in Medicare. HCBS-AMH providers must submit proof of approval and adhere to the appropriate rules, licensing and regulations of the state in which they operate.
Case Management Services	**MH Case Management/MR Case Management.** To enroll in Texas Medicaid, MH case management providers must contact DSHS at 512-206-5288 to be approved. Local mental health (MH) providers, with the approval of DSHS, are eligible to apply for MH case management services. To enroll in Texas Medicaid, MR case management providers must contact DADS at 512-438-3011 to be approved. Local mental retardation (MR) providers, with the approval of DADS, are eligible to apply for MR services coordination. You must attach a copy of your approval letter from the State of Texas. **Note:** *Texas Medicaid Managed Care Organizations (MCO) may credential with providers other than local mental health authorities for MH Case Management and MR Case Management services. These private providers should seek fee-for-service enrollment under the appropriate Traditional Services provider type. It is not necessary to obtain an approval letter from the State of Texas.*
Case Management Services	**MH Rehab.** To enroll in Texas Medicaid, MR rehabilitative services providers must contact DSHS at 512-206-5288 to be approved. Local mental health (MH) providers, with the approval of DSHS, are eligible to apply for MH rehabilitative services. You must attach a copy of your approval letter from the State of Texas. **Note:** *Texas Medicaid Managed Care Organizations (MCO) may credential with providers other than local mental health authorities for MH Rehab services. These private providers should seek fee-for-service enrollment under the appropriate Traditional Services provider type. It is not necessary to obtain an approval letter from the State of Texas.*
Case Management Services	**Women, Infant, & Children (WIC) (Immunization Only).** To be eligible as a qualified provider for presumptive eligibility determinations the following federal requirements must be met. The provider must be 1) an eligible Medicaid provider; 2) provide outpatient hospital services, rural health clinic services, or clinic services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician (includes family planning clinics); and 3) receive funds from or participate in the WIC program.
Case Management Services	**Youth Empowerment Services (YES) Waiver.** To enroll in Texas Medicaid, YES Waiver providers must contact DSHS at YESWaiver@dshs.state.tx.us to be approved. Upon approval by DSHS potential providers must enroll as a Medicaid provider for YES Waiver. You must attach a copy of your YES Waiver DSHS contract.
Texas Medicaid Identification Form – Comprehensive Care Program (CCP) Services	
CCP Services	**Dietitian.** Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to CCP clients. Providers of nutritional services and counseling must be licensed by the Texas State Board of Examiners of Dietitians in accordance with the Licensed Dietitians Act, Article 4512h.

Item	Instructions
CCP Services	**Financial Management Services Agency (FMSA).** To enroll in Texas Medicaid, FMSA providers must submit their contract with the Department of Aging and Disability Services as a Financial Management Services Agency provider.
CCP Services	**Licensed Vocational Nurse (LVN).** Independently enrolled licensed vocational nurses may also enroll to provide private duty nursing (PDN) under Texas Medicaid CCP. In order to enroll, the LVN must submit a plan of RN supervision, including the name and license number of the RN providing the supervision.
CCP Services	**Milk Donor.** To enroll in Texas Medicaid, the provider must adhere to quality guidelines consistent with the Human Milk Bank Association of Northern America.
CCP Services	**Occupational Therapist (OT-CCP).** HHSC allows Medicaid enrollment of independently practicing licensed occupational therapists in CCP. Licensed HCSSAs are also able to provide occupational therapy in CCP.
CCP Services	**Pharmacy.** Pharmacy providers are eligible to enroll in CCP. To be enrolled in CCP, the pharmacy must first be enrolled in the Texas Medicaid Vendor Drug Program (VDP). Pharmacies enrolling as CCP-only providers do not require Medicare certification to enroll. Only taxonomy code 336000000X is available for selection during the enrollment process. *See "Traditional Services – Pharmacy Group" for additional information about pharmacies.*
CCP Services	**Physical Therapist (PT-CCP).** The Medicare enrollment requirement is waived for therapists providing services only to THSteps-eligible clients who are 20 years of age and younger and who are not receiving Medicare benefits. Physical therapy services may also be provided by a licensed HCSSA. CCP physical therapy may be provided by either a licensed and certified home health provider or licensed HCSSA, and physical therapy through Medicaid home health services may be provided by a licensed and certified HCSSA.
CCP Services	**Prescribed Pediatric Extended Care Center.** To enroll in the Texas Medicaid Program, a Prescribed Pediatric Extended Care Center (PPECC) provider must be licensed by the Texas Department of Aging and Disability Services (DADS). PPECC providers must enroll as a facility and are not required to enroll in Medicare. PPECC providers must submit proof of their licensure and adhere to the appropriate rules, licensing and regulations of the state in which they operate.
CCP Services	**Registered Nurse (RN).** Independently enrolled registered nurses may also enroll to provide private duty nursing under CCP.
CCP Services	**Service Responsibility Option (SRO).** To enroll in the Texas Title XIX Medicaid Program, Service Responsibility Option providers must complete the Texas Medicaid enrollment application. Providers of personal assistance services must submit their contract with the Department of Aging and Disability Services as a Service Responsibility Option provider.
CCP Services	**Social Worker (LCSW-ACP).** To enroll in Texas Medicaid independently or as a group, a licensed clinical social worker (LCSW) must be licensed through the Texas State Board of Social Work Examiners as a LCSW and be enrolled in Medicare or obtain a pediatric practice exemption through TMHP Provider Enrollment. Practitioners holding a temporary license are not eligible to enroll in Medicaid. Social Workers can enroll as groups or into multi-specialty or behavioral health groups. If enrolling into a Medicare enrolled multi-specialty group, Medicare enrollment is required.

Item	Instructions
CCP Services	**Speech Therapist (SLP).** HHSC allows enrollment of independently practicing licensed speech-language pathologists under the THSteps-CCP. Texas Medicaid enrolls and reimburses speech-language pathologists for CCP services only.
Texas Medicaid Identification Form – Other Texas Medicaid Services	
Texas Health Steps (THSteps) services (i.e., EPSDT)	Check the box on page 1-4 if you elect not to participate as a provider for THSteps preventive medical checkups. If you decided at a later time to participate as a provider for THSteps preventive medical checkups, you will be required to complete and submit the THSteps Provider Enrollment Application that is available on the TMHP website at www.tmhp.com. By leaving this box unchecked, you may be issued a THSteps medical provider identifier in addition to the provider identifier for your requested provider type. To enroll in the THSteps program, a provider must be a licensed physician (MD, DO); physician assistant (PA); clinical nurse specialist (CNS); nurse practitioner (NP); certified nurse midwife (CNM); federally qualified health centers (FQHC); health-care provider of a facility (public or private) capable of performing the required medical checkup procedures under the direction of a physician; (such as a regional and local health department; family planning clinic; migrant health clinic; community-based hospital and clinic; maternity clinic; rural health clinic; home health agency; or school-based health center).
Texas Vaccines for Children Program (TVFC)	Check the appropriate boxes in response to the questions. Providers that provide routinely recommended vaccines to children who are 18 years of age and younger can apply to receive free vaccines from TVFC. The TVFC application is attached at the end of this Texas Medicaid Provider Enrollment Application and must be completed and submitted as part of this application.
Texas Medicaid Provider Enrollment Application	
A.1 - A.3 Provider of Services Information	This section is for provider demographic information. Provide complete and correct information as required.
A.4 Texas Women's Health Program (TWHP)	Choose the appropriate statement. If you will be rendering services for TWHP clients, you must complete and submit the Texas Women's Health Program Certification form with this application. This form must be completed and submitted by providers that render family planning services to clients who participate in the Texas Women's Health Program. An original signature is required. This form cannot be faxed to TMHP. The form is located in Appendix A of this application. **Important:** Under Texas Human Resources Code, Section 32.024(c-1), and Title 1 of the Texas Administrative Code, Sections 354.1361 through 354.1364, the provider or the provider's affiliated organization is not qualified to participate in and is ineligible to bill for services provided through the Texas Women's Health Program if the provider or anyone in the provider's organization performs or promotes elective abortions, or is an affiliate of another entity that performs or promotes elective abortions.

Item	Instructions
B.1 - B.2 Disclosure of Ownership and Control Interest Statement	Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements. **Note:** *Each creditor with a security interest in a debt that is owed by the Provider if the creditor's security interest is protected by at least 5% of the provider's property must be listed in this form. Every individual and entity on the list must complete and submit a PIF-2 form.*
B.3 PIF-2	A separate copy of the Principal Information Form (PIF-2) must be completed in full for each principal, subcontractor, and creditor of the Provider, before enrollment.
C. Group Practice	Group practice information. If this enrollment is for a group practice, please complete Section C, and provide complete and correct information as required.
D. PIF-1	Each Provider must complete the Provider Information Form (PIF-1), before enrollment. **Important:** *The physical address is where health care is rendered. In the Physical Address field, providers MUST enter the* ***physical address*** *where the services are rendered to clients; the accounting, corporate, or mailing address must NOT be entered in the physical address field. If a site visit is required and cannot be conducted because the physical address was not provided, the enrollment application will be denied.*
HHSC Medicaid Provider Agreement	Complete the required information at the beginning of the form, read the agreement information, and sign and date the agreement to indicate that you have read and agree with the terms of enrollment as required by the Texas HHSC. **Important:** *The physical address is where health care is rendered. In the Physical Address field, providers MUST enter the* ***physical address*** *where the services are rendered to clients; the accounting, corporate, or mailing address must NOT be entered in the physical address field. If a site visit is required and cannot be conducted because the physical address was not provided, the enrollment application will be denied.*
IRS W–9 Form	Provide complete and correct information as required.

ADDITIONAL INSTRUCTIONS - Appendix A

The following are instructions for the additional attachments available in Appendix A:

Item	Instructions
Corporate Board of Directors Resolution	This form is required if the enrolling provider is incorporated. This form must be notarized, and an original signature is required. This form **cannot** be faxed to TMHP.
Medicaid Audit Information Form	This form must be completed and submitted by facilities.
Physician Letter of Agreement for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers	Upon initial enrollment and upon revalidation every 5 years, the CNM or LM must complete and submit to TMHP with the enrollment application this agreement affirming the LM's referring or consulting physician arrangement or the CNM's supervising physician arrangement. A separate agreement must be submitted for each referring or consulting physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the referring or consulting physician. A new agreement must also be completed and submitted to TMHP when a new arrangement is made and when changes to an arrangement are made. The new agreement must be submitted to TMHP with all appropriate signatures within 10 business days of a cancellation or change.
Electronic Funds Transfer (EFT) Notification	To enroll in the EFT program, complete the attached Electronic Funds Transfer (EFT) Notification. You must return a voided check or signed letter from your bank on bank letterhead with the notification to the TMHP address indicated on the form.
Texas Vaccines for Children Program (TVFC): Provider Enrollment	Texas Medicaid does not reimburse for vaccines available from Texas Vaccines for Children (TVFC) program. If you do not currently receive free vaccines from TVFC, and if your clinic/practice provides routinely recommended vaccines to children who are 18 years of age and younger, you may be eligible to enroll in the Texas Vaccines for Children Program. In order to participate in the Texas Vaccines for Children Program and/or to have federally and state-supplied vaccines provided to you at no cost, complete the Texas Vaccines for Children Program Enrollment form and submit the form with this Texas Medicaid Provider Enrollment Application.
Texas Women's Health Program (TWHP) Certification Form	Refer to the TWHP instruction box above for additional information.
The following forms must be obtained from other sources and submitted with this application as appropriate for the requested provider type:	
Franchise Tax Account Status Page	This certificate must be obtained from the Texas State Comptroller's Office website at http://www.window.state.tx.us/taxinfo/coasintr.html. There is no charge for this request. Providers who answer "yes" to the question "Do you have a 501(c) (3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status Page from the State Comptroller's Office.

CONTACT INFORMATION – Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address identified on this application as the location where Medicaid services are being provided.

Contact Name: *Last*	*First*	*Middle Initial*

Contact Telephone Number:	**Contact Fax** *(if applicable)*:

Email Address *(if applicable)*:

Address: *Number*	*Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Medicare Enrollment Information

REQUIRED: Medicare enrollment is a prerequisite for Medicaid enrollment if you render services for clients who are eligible for Medicare.

Are you using a Medicare certification number for this enrollment? ☐ Yes ☐ No

Important: Do not continue with this application if your Medicare certification is pending. Once you have received a Medicare certification number, you may submit an application (an online application is recommended) for enrollment into Texas State Health-Care Programs. Your enrollment effective date will be retroactive to your Medicare certification date. Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service.

If you are eligible to request a Medicare waiver, choose one of the following and continue with this application:

☐ I certify my practice is limited to individuals birth through 20 years of age. I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled. A signed Explanation / Justification letter on company letterhead must be submitted to TMHP with submission of this application's signature page for consideration of the Medicare Waiver Request.

☐ I certify that the service(s) I render is/are not recognized by Medicare for reimbursement. I further certify the claims for these services will not be billed to Medicare (this includes Medicare crossover claims). I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled. A signed Explanation / Justification letter on company letterhead must be submitted to TMHP with submission of this application's signature page for consideration of the Medicare Waiver Request.

Surety Bond Information

REQUIRED: DME suppliers are required to submit proof of a valid surety bond* when submitting: 1) an initial enrollment application to enroll in Texas Medicaid, 2) an enrollment application to establish a new practice location, 3) an enrollment application for re-enrollment in Texas Medicaid.

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to the Department of State Health Services (DSHS).

Are you a government owned or operated entity?

- ☐ Yes, I understand that proof of my government owned or operated status must be received before my application will be considered complete.
- ☐ No

Note: *If you are a government owned or operated entity then a surety bond is not required.*

Are you requesting a waiver from the surety bond requirement?

- ☐ **Yes, I understand that a signed explanation/justification letter on company letterhead requesting the surety bond waiver must be received before my application will be considered complete**.
- ☐ No

* The Surety Bond Form can be found on the TMHP website at www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx.

Application Payment Form

In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications for a new practice location
- Applications received in response to re-enrollment

An application fee is not required and will not be accepted if the provider is enrolled in Medicare, another State's Medicaid program, or another Texas State agency. Providers will be required to submit details and/or payment of other programs or agencies to TMHP with submission of this application.

I am Not Using a Medicare Number for This Enrollment

Instructions: *If you are not using a Medicare certification number for this enrollment, select ONE of the following:*

☐ I am submitting the application fee to Texas Medicaid by paper check, money order, or cashier's check with this application.

Note: *Providers must include a check, money order, or cashier's check with their Texas Medicaid provider enrollment packet submission for the application fee. Cash cannot be accepted. Make the check payable in the amount of $553.00 to Texas Medicaid & Healthcare Partnership (TMHP). Include the Portal Ticket Number on the check and print the PEP Cover letter. Mail the printed PEP Cover letter with the check.*

☐ I attest that I have already paid the application fee to another state's Medicaid program or CHIP program and have been approved for enrollment in another state's Medicaid program or CHIP program. My proof of payment and enrollment is attached to this application. I understand that if my proof of payment to another state's Medicaid program or CHIP program is found to be unacceptable for any reason, I may be required to pay an application fee towards my Texas Medicaid enrollment application.

☐ I am requesting an application fee waiver due to financial hardship. My documentation that supports my request is attached to this application. I understand that I must submit a letter (and supporting documentation) with my enrollment application that details the reason(s) I am unable to pay an application fee. I understand that if the waiver request is denied, I will be required to submit an application fee if I wish to proceed with the Texas Medicaid enrollment process.

Note: *If hardship waiver was issued by another state, you must also request a waiver from Texas Medicaid.*

☐ The application fee is not applicable for my provider type.

Texas Medicaid Identification Form

TYPE OF ENROLLMENT:

☐ New enrollment (new provider, practice location, etc.) ☐ Provider re-enrollment

REQUESTING ENROLLMENT AS:

Select only one of the following options. Selecting more than one of the following options may result in a delay in processing this enrollment application.

☐ Individual ☐ Facility ☐ Group ☐ Performing Provider

Note: *For group enrollment, single-specialty groups must choose a specialty from the services list below. Multi-specialty groups must choose "Multi-speciality" from the services list below.*

LIST NPI: _____

(NPI not required for Financial Management Services Agency [FMSA], Milk Donor Bank, Personal Assistance Services, and Service Responsibility Option [SRO])

ADDITIONAL ENROLLMENT:

☐ I do **not** wish to participate as a provider in the CSHCN Services Program.

Please check only the appropriate box to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to the instructions.

PROVIDER TYPE:

Traditional Services

☐ Ambulance/Air Ambulance ★ ✚ ▲

☐ Ambulatory Surgical Center (ASC) ★ ✚ ▲

☐ Anesthesiologist Assistant ★ ✪ ▲

☐ Audiologist

☐ Birthing Center ▲

☐ Catheterization Lab ★

☐ Certified Nurse Midwife (CNM) ★ ▲ ▼

☐ Certified Registered Nurse Anesthetist (CRNA) ★ ▲

☐ Chemical Dependency Treatment Facility ▲

☐ Chiropractor ★ ▲

☐ Community Mental Health Center ★

☐ Comprehensive Health Center (CHC) ★

☐ Comprehensive Outpatient Rehabilitation Facility (CORF) ★

☐ Dentist/Doctor of Dentistry as a Limited Physician ★ ✪ ▲

☐ Durable Medical Equipment (DME) ♦

☐ Durable Medical Equipment/Home Health

☐ Family Planning Agency ✚ ▼

☐ Federally Qualified Health Center (FQHC) ★ ▼

☐ Federally Qualified Look-alike (FQL) ▼

☐ Federally Qualified Satellite (FQS) ★ ▼

☐ Freestanding Psychiatric Facility ✚ ▲ ★

☐ Freestanding Rehabilitation Facility ★

Continued on next page

Legend:

- ● Approval Letter/Contract required
- ✪ Eligible for Medicare waiver request (you must check the Medicare waiver request box on page 1-1)
- ▲ License/certification required
- ★ Medicare number required
- ✚ Must designate if public provider
- ♦ Palmetto number required
- ▼ Texas Women's Health Program (TWHP) (Certification required for reimbursement)

Continued from previous page

- ☐ Genetics ✚ ▲
- ☐ HCSSA ▲
- ☐ Hearing Aid ▲
- ☐ Home Health ★ ▲
- ☐ Hospital — In-State ✚ ▲ ★
- ☐ Hospital Ambulatory Surgical Center (HASC) ✚
- ☐ Hospital — Military ✚ ▲ ★
- ☐ Hospital — Out-of-State ✚ ▲ ★
- ☐ Hyperalimentation ♦
- ☐ Independent Diagnostic Testing Facility (IDTF) ★ ✚
- ☐ Independent Lab (No Physician Involvement) ★ ✚
- ☐ Independent Lab (Physician Involvement) ★ ✚
- ☐ Licensed Marriage and Family Therapist (LMFT) ▲
- ☐ Licensed Professional Counselor (LPC) ▲
- ☐ Licensed Midwives ▲ ▼
- ☐ Maternity Service Clinic (MSC) ✚ ▼
- ☐ Multi-Specialty Group ★ ✪ ▼
- ☐ Nurse Practitioner/Clinical Nurse Specialist (NP/CNS) ★ ✪ ▲ ▼
- ☐ Occupational Therapist (OT) ★ ▲
- ☐ Optician ★
- ☐ Optometrist (OD) ★ ✪ ▲
- ☐ Orthotist ★ ✪ ▲
- ☐ Outpatient Rehabilitation Facility (ORF) ★
- ☐ Personal Assistant Services/PCS ▲
- ☐ Pharmacy Group ★
- ☐ Pharmacist ★ ▲
- ☐ Physical Therapist (PT) ★ ▲
- ☐ Physician (MD, DO) ★ ✪ ▲ ▼
  OB/GYN and Pediatricians not required to have a Medicare Number
- ☐ Physician Assistant ★ ✪ ▲ ▼
- ☐ Physiological Lab ★
- ☐ Podiatrist ★ ▲
- ☐ Portable X-Ray ★
- ☐ Prosthetist ★ ✪ ▲
- ☐ Prosthetist - Orthotist (choose if licensed as both) ★ ✪ ▲
- ☐ Psychologist ★ ▲
- ☐ Qualified Rehabilitation Professional (QRP) ▲
- ☐ Radiation Treatment Center ★
- ☐ Radiological Lab ★
- ☐ Renal Dialysis Facility ★ ✚ ▲
- ☐ Respiratory Care Practitioner (CRCP) ▲
- ☐ Rural Health Clinic – Hospital, Freestanding ★ ✚ ▼
- ☐ Skilled Nursing Facility ★ ▲
- ☐ Social Worker (LCSW) ★ ▲
- ☐ SHARS — School, Co-op, or School-Based Health Center✚
- ☐ Specialized/Custom Wheeled Mobility - CCP
- ☐ Specialized/Custom Wheeled Mobility - Home Health
- ☐ TB Clinic ✚ ●
- ☐ Vision Medical Supplier (VMS) ♦

Legend:

- ● Approval Letter/Contract required
- ✪ Eligible for Medicare waiver request (you must check the Medicare waiver request box on page 1-1)
- ▲ License/certification required
- ★ Medicare number required
- ✚ Must designate if public provider
- ♦ Palmetto number required
- ▼ Texas Women's Health Program (TWHP) (Certification required for reimbursement)

Case Management Services

- ☐ Blind Children's Vocational Discovery & Development Program ●
- ☐ Case Management for Children and Pregnant Women ▲ ●
- ☐ Early Childhood Intervention (ECI) ✚ ●
- ☐ Financial Management Services Agency (FMSA) ●
- ☐ Home and Community Based Service - Adult Mental Health (HCBS-AMH)
- ☐ MH Case Management/MR Case Management ✚ ●
- ☐ MH Rehab ●
- ☐ Service Responsibility Option (SRO) ● $
- ☐ Women, Infants & Children (WIC) — Immunization Only ●
- ☐ Youth Empowerment Services (YES) Waiver ✚ ●

Comprehensive Care Program (CCP) Services

- ☐ Dietician ▲
- ☐ Licensed Vocational Nurse (LVN) ▲
- ☐ Milk Donor
- ☐ Occupational Therapist (OT-CCP) ▲
- ☐ Pharmacy ●
- ☐ Physical Therapist (PT-CCP) ▲
- ☐ Prescribed Pediatric Extended Care Center ▲
- ☐ Registered Nurse (RN) ▲
- ☐ Social Worker (LCSW-ACP) ▲
- ☐ Speech Therapist (SLP) ▲

Texas Health Steps (THSteps) Services (EPSDT)

☐ I do not wish to participate as a provider for THSteps preventive medical checkups.

Texas Vaccines for Children Program (TVFC)

Texas Medicaid does not reimburse for vaccines available from Texas Vaccines for Children (TVFC) program.

☐ Yes ☐ No Do you currently receive free vaccines from TVFC? *(if* **No***, answer the next question)*

☐ Yes ☐ No Does your clinic/practice provide routinely recommended vaccines to children birth through 18 years of age? *(If* **Yes***, complete the Texas Vaccines for Children Program Enrollment form at the back of this application)*

Legend:

- ● Approval Letter/Contract required
- ✪ Eligible for Medicare waiver request (you must check the Medicare waiver request box on page 1-1)
- ▲ License/certification required
- ★ Medicare number required
- ✚ Must designate if public provider
- ♦ Palmetto number required
- ▼ Texas Women's Health Program (TWHP) (Certification required for reimbursement)

Texas Medicaid Provider Enrollment Application

- All information must be completed and contain a valid signature to be processed. If a question or answer does not apply, enter "N/A".
- Use blue or black ink.

Section A: Provider of Service Information

All applicants, complete the following information.

A.1 Provider Type Specific Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable.

Name of Provider Enrolling: Group/Company or Last Name	First	Middle Initial	
Public/Private entities: (required of all providers)	**Definition** — *Public entities are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.*		
	Are you a private or public entity?		☐ Private ☐ Public
	If you are a public entity, are you required to certify expended funds?		☐ Yes ☐ No
	Name and address of a person certifying expended funds:		
Facilities only:	**Is this a freestanding facility?**		☐ Yes ☐ No
	Is this a hospital-based facility?		☐ Yes ☐ No
	Is this an ESRD facility?		☐ Yes ☐ No
	If **Yes**, *what is your composite rate?*		
Hearing aid providers only:	**Are you a physician?**		☐ Yes ☐ No
	Are you a fitter/dispenser?		☐ Yes ☐ No
	Are you an audiologist?		☐ Yes ☐ No
	Will you be conducting evaluations?		☐ Yes ☐ No
	Will you be dispensing hearing aids?		☐ Yes ☐ No
	Do you provide hearing services for children?		☐ Yes ☐ No
School Health and Related Services (SHARS) providers only:	**Are you enrolling as a school district?**		☐ Yes ☐ No
	If **Yes**, *give school six-digit T.E.A. number:*		
	Are you enrolling as a special education co-op? *If* **Yes**, *attach a list of all school districts in the co-op that will be providing SHARS services. Provide the following information for each school district:* • *Complete address* • *School District Number* • *T.E.A. number.*		☐ Yes ☐ No

<table>
<tr><td rowspan="6">Hospital providers only:</td><td>Are you a hospital facility?</td><td colspan="2">☐ Yes ☐ No</td></tr>
<tr><td colspan="3">If Yes, indicate the type of hospital facility.
☐ Children's ☐ Teaching Facility ☐ Long Term
☐ Short Term ☐ Private Full Care ☐ Private Outpatient
☐ Psychiatric ☐ Rehabilitation ☐ State Owned</td></tr>
<tr><td>Do you have children's unit(s)?</td><td colspan="2">☐ Yes ☐ No</td></tr>
<tr><td>Date of Construction?</td><td colspan="2"></td></tr>
<tr><td rowspan="2">If you are a hospital facility, what is your average daily room rate for private and semi-private?</td><td>Private</td><td>Semi-Private</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Current Beds:</td><td colspan="2"></td></tr>
<tr><td>Home Health and Hospital providers only:</td><td colspan="3">Do you offer telemonitoring services? ☐ Yes ☐ No

By checking yes, I certify my organization or facility has all of the necessary equipment and devices to render telemonitoring services. I certify that all telemonitoring staff are qualified to install the needed telemonitoring equipment and to monitor the client data that is transmitted according to the client's care plan. I certify that my organization or facility has written protocols, policies, and procedures on the provision of home telemonitoring services, and those written protocols, policies, and procedures are available to the Health and Human Services Commission (HHSC) or its designee upon request</td></tr>
<tr><td>THSteps and Family Planning Providers Only</td><td colspan="3">Are you licensed as a Physician Assistant (PA) or a Nurse recognized as an Advanced Practice Registered Nurse (APRN)? ☐ Yes ☐ No

If Yes please list the appropriate Sub-Specialty in section A.2. (Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or PA).</td></tr>
</table>

A.2 Provider Specialty/Taxonomy Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable.

Primary Specialty:	Sub-Specialty: (if applicable)
Primary Taxonomy Code:	

If the applicant is a performing provider, complete the following:

Group TPI: (if enrolling as a performing provider into an existing group)
Group Medicare Number: (if applicable)

A.3 Provider Demographic Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable.

Existing Texas Provider Identifiers (TPIs): *(List all TPIs associated with the individual/group/facility enrolling)*

Group/Company DBA Name:	**Title/Degree:**	**Do you want to be a limited provider?** *(see Useful Information)*
		☐ Yes ☐ No
Provider business e-mail: *(if applicable)*	**Provider website address:** *(if applicable)*	
Telephone number:	**Physical address FAX number:**	
Legal name according to the IRS: *(must match the legal name field on the W-9 & Disclosure of Ownership)*	**Accounting/billing address FAX number:** *(optional)*	
Federal/Employer Tax ID number:		

Accepting new clients:	**Gender served:**	**Client age restrictions:**
☐ Yes ☐ No	☐ Male ☐ Female ☐ All	

Counties served:

Indicate your reason for applying to join the Texas State Health-Care Programs: *(Select one)*

- ☐ Access to an online application
- ☐ Adding a new location
- ☐ Adding performing provider to an existing group
- ☐ Electronic claims processing
- ☐ Improved administrative processes
- ☐ Incentive programs
- ☐ Learned about Texas State Health-Care Programs at a conference
- ☐ Learned about Texas State Health-Care Programs at a provider workshop
- ☐ Recruited by Texas State Health-Care Programs staff
- ☐ Recruited by TMHP Provider Relations representative
- ☐ Re-enrolling a provider under an existing provider identifier
- ☐ Reimbursement increases
- ☐ Timely reimbursement

A.4 Texas Women's Health Program (TWHP)

Choose one of the following:

☐ I do not provide services for TWHP clients.

☐ I provide services for TWHP clients. (If you provide services for TWHP clients, you must complete the Texas Women's Health Program Certification in Appendix A.)

Section B: Disclosure of Ownership and Control Interest Statement

B.1 Disclosure of Ownership Instructions

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS
Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS
These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information
(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals
List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

*All individuals listed on section IIIa must submit a PIF-2

ITEMS IV through VII – Changes in Provider Status
Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership
(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management
If the answer is **Yes**, list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing
If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation
A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity
If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship
Please disclose any of familial relationships between principals and/or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

B.2 Disclosure of Ownership Form (3 Pages)

This form is required for all individuals, groups, and facilities (exclude performing providers and SHARS providers).

I.	Identifying information		
(a)	**Legal Name:** *(according to the IRS)*	**DBA:**	**Telephone number:**
	Physical/Corporate Address: Number Street Suite City State ZIP		

II.	**Answer the following questions by checking Yes or No.** *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	**Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?**	☐ Yes ☐ No
(b)	**Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months?** *(Medicare providers only)*	☐ Yes ☐ No

III.	**Owners, Partners, Officers, Directors, and Principals** *All individuals and entities identified in this section are required to complete a PIF-2 which must be submitted with this enrollment application.*		
(a)	**Identify individuals who are sole proprietor or owners, partners, officers, directors, and principals [as defined in Principal Information Form (PIF-2)] of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect.** ***(Add additional pages if necessary.)***		
	1.	**Name:**	**Percentage Owned:**
	2.	**Name:**	**Percentage Owned:**
	3.	**Name:**	**Percentage Owned:**
	4.	**Name:**	**Percentage Owned:**

(b)	**Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*		
	Name:	**Address:**	**Federal Tax ID:**

(c)	**Do you currently have a creditor with a security interest in a debt that is owed by you?** **Is the creditor(s) security interest protected by at least 5 percent of your property?**		☐ Yes ☐ No ☐ Yes ☐ No
	List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property. *All listed creditors must also complete a Principal Information Form (PIF-2).*		
	Last Name/Company Name:	**First Name:**	**Percent of Security Interest:**
(d)	**Type of Entity:** *Select only one - must match entity on W9*		
	☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Limited liability company. (*Enter the tax classification [C=C corporation, S=S corporation, P=partnership*]) _____ ☐ Trust/estate ☐ Other *(specify)* _____ _____		
(e)	**If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.** ***Note:*** *Each director identified in this section must also complete a PIF-2. All PIF-2 documents must be submitted with this application. Attach additional pages if needed.*		
	Remarks:		

IV.	**Ownership**		
(a)	**Has there been a change in ownership or control within the last year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(b)	**Do you anticipate any change of ownership or control within the year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*		☐ Yes ☐ No
	If **Yes**, *give date:*		
(d)	**Are any of the new owners related to any of the former owners?**		☐ Yes ☐ No
(e)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If yes, please list the name of the former owners below.*		☐ Yes ☐ No
	Last Name:	**First Name:**	Middle Initial:

V.	**Management**	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If **Yes**, *give date of change in operations:*	

VI.	Staffing	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	Affiliation		
(a)	**Is the provider identified in Section I. above chain affiliated?**		☐ Yes ☐ No
	If **Yes**, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:*		
	Name	Address	Federal Tax ID

VIII.	Capacity			
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*			☐ Yes ☐ No
	If **Yes**, *give:*	**Year of change:**	**Current Beds:**	**Prior Beds:**

IX.	Disclosure of Relationship		
(a)	**Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):**		
	Provider/Principal 1:	**Has a Relationship as:**	**To Provider/Principal Name 2:**

Please Note: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form must be completed with signature and notary stamp or seal.
- Certificate of Formation or Certificate of Filing or Certificate of Authority.
- Franchise Tax Account Status Page.

There is no charge for this request. This certificate must be obtained from the Texas State Comptroller's Office website at http://www.window.state.tx.us/taxinfo/coasintr.html.

Do you have a 501(c)(3) Internal Revenue Exemption? ☐ Yes ☐ No

Providers who answer "yes" to the question "Do you have a 501©(3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status Page from the State Comptroller's Office.

B.3 Principal Information Form (PIF-2) (6 Pages)

Required for any person or entity that meets the definition of a "Principal" or "Subcontractor" as defined below.

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the Provider Agreement.

Check person or entity: ☐ Person ☐ Entity *If **Entity**, please complete the following information.*				
Tax ID number as shown on the W9 IRS form:		**Legal name as shown on the W9 IRS form:**		
Company Name:				
Address as shown on the W9 IRS form: Number Street	Suite	City	State	ZIP
How is the entity organized to conduct business activities? *Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental*				
Do you conduct business under an assumed name? *If **Yes**, provide the assumed name below.*			☐ **Yes** ☐ **No**	
Assumed Name:				

If you selected ***Person*** *above, please complete the following information.*	
Last Name:	**First Name/Middle Initial:**
Maiden Name:	**List any other alias, name, or form of your name ever used:**

The following information must be completed by all Principals, Subcontractors, and Creditors. For additional names or addresses, attach pages as necessary.

Check **principal** or **subcontractor** ☐ Principal ☐ Subcontractor

Physical address: Number	Street	Suite	City	State	ZIP

Accounting/billing address: Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☐ Management company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Social Security Number:	**Federal Tax ID number:**
Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?		
☐ Yes ☐ No *If Yes, provide the following information.*		
1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	License Accreditation Certification Number:
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):

Previous Physical address: Number	Street	Suite	City	State	ZIP
Previous Accounting address: Number	Street	Suite	City	State	ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*

Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown: (attach additional sheets if necessary)*	
Effective date of your role in the provider organization: MM/DD/YYYY	**Do you have a relationship with a separate provider?**
	☐ Yes ☐ No
List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*	

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	☐ Yes ☐ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No

If ***Yes*** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency. (attach additional sheets if necessary)*

"Convicted" means that:

(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

- **(1) There is a post-trial motion or an appeal pending, or**
- **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;**

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for arrest?	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

Are you currently subject to court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *please provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Section C: Group Practice

This section is only for applicants that are enrolling as a group practice.

Note: *All performing providers listed here must complete a separate PIF-1 and HHSC Medicaid Provider Agreement. See the instructions for additional information.*

If the applicant is enrolling as a single-specialty or multi-specialty group, list all performing providers that will be enrolled as part of the group.

1.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
2.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
3.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
4.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
5.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**
6.	**Name:**		**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY	**Medicare number:**

Section D: Provider Information Form (PIF-1) (6 Pages)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement or other State Health-Care Program Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS or its designee.

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Last, First, Middle Initial OR Group/Company name:	**Maiden Name:**
List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI):** *(10-digit)*
Primary Taxonomy Code: *(10-digit)*	
Secondary Taxonomy Code: *(10-digit – the provider may indicate up to 15 taxonomy codes; attach additional pages if needed)*	
Non-Texas-enrolled Taxonomy Code: *(these codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid)*	

For additional names or addresses, attach pages as necessary.

Physical Address (where health care is rendered): *Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.* Number Street Suite City State ZIP
Accounting/Billing Address: Number Street Suite City State ZIP
If your accounting address is different than your physical address, indicate your relationship to the accounting address:
☐ Third Party Biller ☐ Management Company ☐ Employer ☐ Self ☐ Other *(explain below)*
If you chose **Other**, *please explain:*

Supervising /Consulting/Referring Physician License Number and State: (if required by your licensing or certification board:	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY

Social Security Number:	Federal Tax ID Number:
Specialty of Practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare Intermediary:** *(if applicable)*
Medicare Provider Number: *(if applicable)*	**Medicare Effective Date:** MM/DD/YYYY *(if applicable)*

Driver's License Number:	State:	Driver's License Expiration Date: MM/DD/YYYY

Date of Birth: MM/DD/YYYY		Gender:	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?

☐ Yes ☐ No *If Yes, provide the following information.*

1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**

3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**

CLIA Certification Number: *(attach a copy of the CLIA certification, if applicable)*
Hospitals providing laboratory services, and independent laboratories (including those located in physician's offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA Certification Address: *(list the address listed on the CLIA Certificate, if applicable)*
Number Street Suite City State ZIP

CLIA Certification Effective Date (*if applicable*):	**CLIA Certification Expiration Date (*if applicable*):**

Previous Physical Address:
Number Street Suite City State ZIP

Previous Accounting Address:
Number Street Suite City State ZIP

Do you plan to use a Third Party Biller to submit your health-care claims?

☐ Yes ☐ No *If* **Yes**, *provide the following information about the billing agent.*

Billing Agent Name:	**Address:**
Federal Tax ID Number:	
Contact Person Name:	**Telephone Number:**

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☐ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐ Yes ☐ No
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No

If **Yes** *was answered to any of the questions, fully explain the details including date, and the state if applicable.*

"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for your arrest?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you currently subject to court-ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

HHSC Medicaid Provider Agreement

Name of provider enrolling:	
Medicaid TPI: *(if applicable)*	**Medicare provider ID number:** *(if applicable)*

Physical address (where health care is rendered): *Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.*

Number	Street	Suite	City	State	ZIP

Accounting/billing address: *(if applicable)*

Number	Street	Suite	City	State	ZIP

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

The current *Texas Medicaid Provider Procedures Manual* (Provider Manual) may be accessed via the internet at www.tmhp.com. Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws governing or regulating Medicaid, and provider further acknowledges and agrees that the provider is responsible for ensuring that all employees and agents of the provider also comply. Provider agrees to acknowledge HHSC's provision of enrollment processes and authority to make enrollment decisions as found in Title 1, Part 15, Chapter 352 of the Texas Administrative Code. Provider is specifically responsible for ensuring that the provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to waste, abuse and fraud, and provider acknowledges and agrees that the provider and its principals will be held responsible for violations of this agreement through any acts or omissions of the provider, its employees, and its agents. For purposes of this agreement, a principal of the provider includes all owners with a direct or indirect ownership or control interest of 5 percent or more, all corporate officers and directors, all limited and non-limited partners, and all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company. Principals of the provider further include managing employee(s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

1.2 State and Federal regulatory requirements.

1.2.1 By signing this agreement, Provider certifies that the provider and its principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal health-care program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 48 CFR, Ch. 3, relating to eligibility for federal contracts and grants.

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify HHSC or its agent within 10 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to HHSC complete information related to any such suspension or restriction.

Provider agrees to disclose all convictions of Provider or Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Send the information to Office of Inspector General, P.O. Box 85211 – Mail Code 1361, Austin, Texas 78708. Fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s).

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's

agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1667. Provider understands and agrees that payment for goods and services under this agreement is conditioned on the existence of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If provider fails to create, maintain, or produce such records in full accordance with this Agreement, provider acknowledges, agrees, and understands that the public monies paid the provider for the services are subject to 100% recoupment, and that the provider is ineligible for payment for the services either under this agreement or under any legal theory of equity.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Inspector General (OIG), and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the Texas Health and Human Services Commission's Office of Inspector General or its designee. Subcontractors include those persons and entities that provide medical or dental goods or services for which the Provider bills the Medicaid program, and those who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and encounter data.

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payer, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

1.3.5 As a condition of eligibility for Medicaid benefits, a client assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (*Texas Administrative Code* Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).

1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent, and to implement an effective method to track submitted claims against payments made by HHSC or its agents.

1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the HHSC Office of Inspector General (OIG). To report waste, abuse or fraud, go to **www.hhs.state.tx.us** and select "Reporting Waste, Abuse, or Fraud". Individuals may also call the OIG hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

2.1.1 the individual's right to self-determination in making health-care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 166) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

2.1.3 the individual's rights under Health and Safety Code, Chapter 166, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Probation Code, Chapter XII, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult clients on the provider's policies concerning the client's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

- School health and related services (SHARS)
- Case management for blind and visually impaired children (BVIC)
- Case management for early childhood intervention (ECI)
- Service coordination for mental retardation (MR)
- Service coordination for mental health (MH)
- Mental health rehabilitation (MHR)
- Tuberculosis clinics
- State hospitals

IV. CLIENT RIGHTS

4.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

4.3 The client must have the right to choose any qualified provider of family planning services.

V. THIRD PARTY BILLING VENDOR PROVISIONS

5.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

Provider must have a written contract with any person or entity for the purpose of billing provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
- Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.
- Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or it's contractor.
- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.
- Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
- Biller and Provider agree to notify the Medicaid program within 5 business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

VI. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the termination date, if any, indicated in the enrollment correspondence issued by HHSC or its agent. If the correspondence/notice of enrollment from HHSC or its agent states a termination date, this agreement terminates on that date with or without other advance notice of the termination date. If the correspondence/notice of enrollment from HHSC or its agent does not state a termination date, this agreement is open-ended and remains effective until either a notice of termination is later issued or termination occurs as otherwise provided in this paragraph. Either party may terminate this Agreement voluntarily and without cause, for any reason or for no reason, by providing the other party with 30 days advance written notice of termination. HHSC may immediately terminate this agreement for cause, with or without advance notice, for the reason(s) indicated in a written notice of termination issued by HHSC or its agent. Cause to terminate this agreement may include the following actions or circumstances involving the provider or involving any person or entity with an affiliate relationship to the provider: exclusion from participation in Medicare, Medicaid, or any other publicly funded health-care program; loss or suspension of professional license or certification; any circumstances resulting in ineligibility to participate in Texas Medicaid; any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program; and any circumstances indicating that the health or safety of clients is or may be at risk. HHSC also may terminate this agreement due to inactivity, with or without notice, if the Provider has not submitted a claim to the Medicaid program for 12 or more months.

VII. ELECTRONIC SIGNATURES

Provider understands and agrees that any signature on a submitted document certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).

Provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

VIII. COMPLIANCE PROGRAM REQUIREMENT

By signing section VIII, Provider certifies that in accordance with requirement TAC 352.5(b)(11), Provider has a compliance program containing the core elements as established by the Secretary of Health and Human Services referenced in §1866(j)(8) of the Social Security Act (42 U.S.C. §1395cc(j)(8)), as applicable.

I attest that I have a compliance plan. ☐ Yes ☐ No

IX. INTERNAL REVIEW REQUIREMENT

Provider, in accordance with TAC 352.5 (b)(1), has conducted an internal review to confirm that neither the applicant or the re-enrolling provider, nor any of its employees, owners, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

I attest that an internal review was conducted to confirm that neither the applicant or the re-enrolling provider nor any of its employees, owners, managing partners, or contractors have been excluded from participation in a program under the Title XVIII, XIX, or XXI of the Social Security Act." ☐ Yes ☐ No

X. ACKNOWLEDGEMENTS AND CERTIFICATIONS

By signing below, Provider acknowledges and certifies to all of the following:

- Provider must notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy and must copy TMHP and HHSC with all the Provider's pleading in the case. A failure to notify TMHP and HHSC of a bankruptcy petition is a material breach of the Provider Agreement.
- Provider has carefully read and understands the requirements of this agreement, and will comply.
- Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the provider information forms (PIF-1) and principal information form (PIF-2), and provider certifies that this information is current, complete, and correct.
- Provider agrees to inform HHSC or its designee, in writing and within 30 calendar days, of any changes to the information submitted in connection with its application to participate in the Medicaid program, whether such change to the information occurs before or after enrollment.
- Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.
- Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment, and may also result in other administrative sanctions that include payment hold, exclusion, debarment, contract cancellation, and monetary penalties.
- Provider agrees to abide by all Medicaid regulations, program instructions, and Title XIX of the Social Security Act. The Medicaid laws, regulations, and program instructions are available through the Medicaid contractor. Provider understands that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicaid.

Name of Applicant: _____

Applicant's Signature: _____ Date: _____

For applicants that are entities, facilities, groups, or organizations, and an authorized representative is completing this application with authority to sign on the applicant's behalf, the authorized representative must sign above and print their name and title where indicated below.

Representative's Name:_____

Representative's Position/Title: _____

IRS W–9 Form

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X

Form **W-9** (Rev. 12-2014)

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Final Checklist

Important: *Only submit the completed pages of the application and any additional required forms and attachments. Do not submit the instruction pages of this application. They are for your reference only.*

1. Complete the following required forms — *All items marked are required.*

- ☒ Texas Medicaid Identification Form *(One for each group, performing provider within the group, individual, or facility included in this enrollment package)*
- ☒ Texas Medicaid Provider Enrollment Application
- ☒ HHSC Medicaid Provider Agreement *(One for each group, performing provider within the group, individual, or facility included in this enrollment package)*
- ☒ Provider Information Form (PIF-1) *(One for each group, performing provider within the group, individual, or facility in this enrollment package)*
- ☒ Principal Information Form (A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal, Subcontractor, and Creditor of the Provider, before enrollment) (performing providers are exempt)
- ☒ Disclosure of Ownership and Control Interest Statement Form (performing providers and SHARS providers are exempt)
- ☒ IRS W-9 Form (performing providers are exempt)
- ☐ Corporate Board of Directors Resolution Form — **Must Be NOTARIZED**
- ☐ Medicaid Audit Form
- ☐ Texas Women's Health Program Certification (TWHP)
- ☐ Physician Relationship Agreement for Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs)
- ☐ Texas Medicaid Surety Bond Form (DME providers and non-government-operated ambulance providers only)

2. If applicable, complete and/or submit the following optional forms.

- ☐ Electronic Funds Transfer (EFT) Notification and copy of a voided check or signed letter from the bank. (The signed letter from the bank must be on the bank's letterhead.)
- ☐ Texas Vaccines for Children (TVFC) Provider Enrollment
- ☐ For CSHCN Services Program enrollment:
  - CSHCN Services Program Identification Form
  - Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program
  - Required Information for Customized Durable Medical Equipment (DME) Providers (as applicable)
  - Required Information for Designation as a Team Member or Affiliated Provider of a CSHCN Services Program Comprehensive Cleft/Craniofacial Team (as applicable)
  - Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider (as applicable)
  - Required Information for Enrollment as a CSHCN Services Program Stem Cell Transplant Facility (as applicable)

3. Obtain signatures — *These must be original signatures. Sworn Statements must be properly notarized by a Notary Public. All items checked are required forms for all providers.*

- ☒ HHSC Medicaid Provider Agreement
- ☒ IRS W-9 Form (performing providers are exempt)
- ☐ Corporate Board of Directors Resolution Form — **Must Be NOTARIZED**
- ☐ Electronic Funds Transfer (EFT) Notification
- ☐ Texas Vaccines for Children (TVFC) Provider Enrollment

4. Attach all required documents

- ☐ **Facility Providers** — Attach a copy of your permit/license.
- ☐ **Clinical Laboratory Providers** — Attach a copy of your CLIA certificate with approved specialty services as appropriate.
- ☐ **FQHC Providers** — Attach a copy of the following:
  - Federally Qualified Health Center Affiliation Affidavit
  - Your grant award
  - Names and addresses of your satellite centers that have been approved by the Public Health Service
- ☐ **Mammography Services Providers** — Attach a copy of the certification of your mammography systems from the Bureau of Radiation Control (BRC).
- ☐ **Freestanding RHC Providers** — Attach a copy of your encounter rate letter from Medicaid.
- ☐ Attach a copy of your approval letter or contract if required. (Refer to the Identification Form for provider types that require approval letter/contract.)
- ☐ **Incorporated Providers** — Attach a copy of the following:
  - Certificate of Formation and Certificate of Filing or Certificate of Authority
  - Franchise Tax Account Status Page or IRS 501(c)(3) Exemption Letter
- ☐ **Out of State Providers** – Attach proof of meeting one of the following criteria:
  - A medical emergency documented by the attending physician or other provider.
  - The client's health is in danger if he or she is required to travel to Texas.
  - Services are more readily available in the state where the client is located.
  - The customary or general practice for clients in a particular locality is to use medical resources in the other state.
  - All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency).
  - The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.
  - The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid)
  - The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.

- The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:
  - Texas Medicaid enrolled providers rely on the services provided by the applicant.
  - Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
- A laboratory may participate as an in-state provider, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:
  - The laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;
  - The laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and
  - The laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefit programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.

☐ **Medicare-enrolled Providers** – Attach a copy of a current MRAN or Medicare approval letter.

5. Include the application fee (if applicable) with the application.

Make check, money order, or cahsier's check payable in the appropriate amount to TMHP.

Only paper checks, money orders, or cashier's checks in the amount of the CMS-directed fee will be accepted. Cash and electronic payments cannot be accepted. The application fee is a condition for enrollment. Applications cannot be processed without the fee.

Application fee is not required and will not be accepted if the provider is enrolled in Medicare, another State's Medicaid program, or another Texas State agency. Providers will be required to submit details and/or payment of other programs or agencies to TMHP with submission of this application.

6. Make a copy for your records.

Be sure to make a copy of all documents for your own records.

7. Mail your application.

Mail your application to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

Appendix A: Additional Forms

The following forms must be attached to this application if applicable to the requested provider type:

- Corporate Board of Directors Resolution
- Medicaid Audit Information Form
- Physician Relationship Agreement for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers
- Electronic Funds Transfer (EFT) Notification
- Texas Vaccines for Children Program (TVFC): Provider Enrollment
- Texas Women's Health Program Certification

Corporate Board of Directors Resolution

THE FOLLOWING FORM IS FOR CORPORATIONS ONLY,
AS INDICATED ON THE DISCLOSURE OF OWNERSHIP, QUESTION III (D).

State Of _____

County Of _____

On The _____ Day Of _____, 20_____, at a meeting of

The Board Of Directors Of _____, A Corporation, held in the city of

_____, in_____ county.

With A Quorum Of The Directors Present, The Following Business Was Conducted:

It was duly moved and seconded that the following resolution be adopted:
Be it resolved that the board of directors of the above corporation do hereby authorize

_____

and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Texas Health and Human Services Commission, and to execute said contract or contracts on behalf of the corporation, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the by–laws and Articles of Incorporation.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the board of directors of

_____,

held on the _____ day of _____, 20_____.

_____
Signature of Secretary

Subscribed and Sworn Before Me, _____, a Notary Public for the County of

_____, on the _____ day of _____, 20_____.

Notary Stamp/Seal

Notary Public, County of _____

State of _____

Signature _____

MESSAGE TO NOTARY:

COMPLETE ALL OF THE BLANKS IN THIS NOTARY STATEMENT.

Medicaid Audit Information Form

HOSPITALS, HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTERS, HOME HEALTH, FREESTANDING PSYCHIATRIC FACILITY, CHRONIC RENAL DISEASE, TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (MH/MR), FEDERALLY QUALIFIED HEALTH CENTER, AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

REQUIRED FORM

Audit Information Form is to be filled out by facilities such as hospitals, home health, rural health, FQHC, and renal dialysis.

Cost reports, for applicable providers, are to be filed according to Medicare regulations. Provide us with the following information:

Medicaid TPI: *(to be completed by TMHP)*

Facility provider name:

Current fiscal year end:

Medicare intermediary: (*name and address of where you send your Medicare cost report)*
Phone:

Contact for cost report information: (*at facility)*
Phone:

Physician's Letter of Agreement

Important: *This form is required for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers.*

According to Texas Health and Human Services Commission (HHSC) rules 1 TAC 354.1253 (c) and 1 TAC 354.1252 (3), certified nurse midwife (CNM) providers and licensed midwife (LM) providers are required to inform HHSC in writing of the identity of a licensed physician or group of physicians with whom the CNM or LM has arranged for referral and consultation in the event of medical complications. For purposes of this rule, "consultation" means discussion of patient status, care, and management.

Instructions: Upon initial enrollment and upon revalidation every 5 years, the CNM or LM must complete and submit to TMHP with the Medicaid provider enrollment application the following agreement affirming the CNM's supervising physician arrangement or the LM's referring or consulting physician arrangement. A separate agreement must be submitted for each physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the physician.

A new agreement must also be completed and submitted to TMHP when a new arrangement is made and when changes to an arrangement are made. *The new agreement must be submitted to TMHP within 10 business days of a cancellation or change.* This agreement must be signed by the CNM or LM and the physician or physician group representative.

Note: *The physician group representative must be a physician in the group, and the license number provided must be the license number of the physician who signs the form. A non-physician cannot sign this form.*

Provider type (Choose one):	**Date agreement is effective with the referring/consulting/supervising physician:**
☐ Certified nurse midwife (CNM) ☐ Licensed midwife (LM)	
CNM or LM Name:	**CNM or LM License Number:**
Referring/Consulting/Supervising Physician Name:	**Referring/Consulting/Supervising Physician License:**

Statement of Affirmation

I affirm that a formal agreement has been made between the physician or physician group identified above and the certified nurse midwife or licensed midwife identified above with regard to referral or consultation. All parties are in agreement that arrangements are in place to discuss the status and management of client care, and for client referral and acceptance of transfer of care if necessary.

CNM/LM Signature: _____ Date:_____

Physician Signature: _____ Date:_____

Please send the completed agreement to the following address:

TMHP
Attn: TMHP Provider Enrollment Department
PO Box 200795
Austin, TX 78720-0795

Electronic Funds Transfer (EFT) Notification (5 pages)

Instructions

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by *ensuring funds are directly deposited into a specified account*.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

> Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

Important: *Submit the completed Electronic Funds Transfer (EFT) Notification form with a copy of a voided check or signed letter from your bank. Call the* ***TMHP Contact Center*** *at* ***1-800-925-9126*** *if you need assistance.*

Return this form to:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Electronic Funds Transfer (EFT) Notification

By submitting a signed copy of the EFT Notification form I agree to the following:

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

As part of the EFT enrollment process and to comply with the Affordable Care Act CAQH CORE Rule 370, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. These data elements will allow you to easily associate your EFT payment with the appropriate ERA remittance advice. You may read more about the CAQH CORE Rule at the CAQH website: **http://caqh.org/**

Complete the required fields on the EFT Notification form as follows:

Provider Information	
Provider Name	Enter the provider's legal name according to the Internal Revenue Service (IRS).
Provider Address	Enter the provider's address including the street, city, state/province and ZIP code/postal code.
Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	Enter the provider's TIN or EIN.
National Provider Identifier (NPI)	Enter the provider's NPI.
Other Identifier(s)	The Billing TPI and other related TPIs (up to a total of nine) for this enrollment.
Assigning Authority	Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid.
Financial Institution Information	
Financial Institution Name	Enter the name of the provider's financial institution
Financial Institution Address:	Enter the provider's financial institution's address including the street, city, state/province and ZIP code/postal code.
Financial Institution Routing Number	Enter the 9-digit routing identifier of the financial institution where EFT payments are to be deposited.
Type of Account at Financial Institution	Enter the type of account the provider will use to receive EFT payments (e.g., checking, saving).
Provider's Account Number with Financial Institution	Enter the provider's account number at the financial institution where EFT payments are to be deposited.
Account Number Linkage to Provider Identifier	Enter the provider's preference for grouping (bulking) claim payments.

Electronic Funds Transfer (EFT) Notification

Submission Information	
Reason for Submission	Select the most appropriate reason for submission of the EFT Notification form: • New Enrollment (New EFT request) • Change Enrollment (EFT change request) • Cancel Enrollment (EFT cancellation request)
Include with Enrollment Submission	Select which document is included with the EFT Notification form.
Authorized Signature	
Written Signature of Person Submitting Enrollment	Signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.
Submission Date	Enter the date the EFT Notification form was signed.
Printed Name of Person Submitting Enrollment	Enter the printed name of the person signing the EFT Notification form.
Printed Title of Person Submitting Enrollment	Enter the printed title of the person signing the EFT Notification form.
Requested EFT Start/Change/Cancel Date	Enter the date on which the requested action is to begin.

Other Data Elements
The other data elements within this form will allow providers to easily associate EFT and Electronic Remittance Advice (ERA) transactions. Refer to the Council for Affordable Quality Healthcare (CAQH) website, **http://caqh.org/** for more information about CORE Rule 370 and the other data elements on the EFT Notification form.

Electronic Funds Transfer (EFT) Notification

Provider Information					
Provider Name *			**Doing Business As Name (DBA)**		
Provider Address					
*Street **	*City **		*State/Province **	*ZIP Code/Postal Code **	*Country Code*

Provider Identifiers Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *	**National Provider Identifier (NPI) ***
Other Identifier(s) *	**Assigning Authority ***
Trading Partner ID	
Provider License Number	**License Issuer**
Provider Type	**Provider Taxonomy Code**

Provider Contact Information		
Provider Contact Name		**Title**
Telephone Number	**Telephone Number Extension**	**Email Address**
Fax Number		

Provider Agent Information					
Provider Agent Name					
Agent Address					
Street	*City*		*State/Province*	*ZIP Code/Postal Code*	*Country Code*
Provider Agent Contact Name			**Title**		
Telephone Number	**Telephone Number Extension**		**Email Address**		
Fax Number					

*** Required field**

Electronic Funds Transfer (EFT) Notification

Federal Agency Information	
Federal Program Agency Name	
Federal Program Agency Identifier	**Federal Agency Location Code**

Retail Pharmacy Information	
Pharmacy Name	**Chain Number**
Parent Organization ID	**Payment Center ID**
NDCP Provider ID Number	**Medicaid Provider Number**

Financial Institution Information			
Financial Institution Name *			
Financial Institution Address *Street **	*City **	*State/Province **	*ZIP Code/Postal Code **
Financial Institution Telephone Number	**Telephone Number Extension**		

Financial Institution Routing Number *	Type of Account at Financial Institution *
Provider's Account Number with Financial Institution *	**Account Number Linkage to Provider Identifier ***
	☐ **Provider Tax Identification Number (TIN):** _____ ☐ **National Provider Identification (NPI):** _____

Submission Information	
Reason for Submission *	**Include with Enrollment Submission ***
☐ **New Enrollment** ☐ **Change Enrollment** ☐ **Cancel Enrollment**	☐ **Voided Check** ☐ **Bank Letter**

Authorized Signature	
Written Signature of Person Submitting Enrollment *	
Printed Name of Person Submitting Enrollment *	**Printed Title of Person Submitting Enrollment ***
Requested EFT Start/Change/Cancel Date *	**Submission Date ***

*** Required field**

Vaccines for Children Program Provider Agreement (8 pages)

VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT		
Instructions: *The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*

VFC VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ☐ Yes ☐ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ☐ Yes ☐ No	Type of training received:

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN *(Optional)*

PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2.	I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories: A. Federally Vaccine-eligible Children (VFC eligible) 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement. B. State Vaccine-eligible Children 1. In addition, to the extent that my state designates additional categories of children as "state vaccine-eligible", I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children. Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are **not** eligible to receive VFC-purchased vaccine.
3.	For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VFC program for five years and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $22.06 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
9.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Texas Department of State Health Services storage and handling recommendations and requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
10.	I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program: **Fraud:** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. **Abuse:** provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the Texas Department of State Health Services to serve underinsured VFC-eligible children, I agree to: a) Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit; b) Vaccinate "walk-in" VFC-eligible underinsured children; and c) Report required usage data Note: *"Walk-in" in this context refers to any underinsured child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve underinsured patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to underinsured patients as well.*
13.	For pharmacies, urgent care, or school located vaccine clinics, I agree to: a) Vaccinate all "walk-in" VFC-eligible children and b) Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. Note: *"Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well.*

14.	I understand this facility or the Texas Department of State Health Services may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Texas Department of State Health Services.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*				
Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*				
Provider Name	**Title**	**License No.**	**Medicaid or NPI No.**	**EIN** ***(Optional)***

Vaccines for Children (VFC) Program
Provider Profile Form

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

Date:_____/_____/ _____ ___ **Provider Identification Number#_____**

FACILITY INFORMATION		
Provider's Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	**State:**	**Zip:**
Telephone:	**Email:**	

FACILITY TYPE (select facility type)

Private Facilities	Public Facilities	
☐ Private Hospital	☐ Public Health Department Clinic	☐ STD/HIV
☐ Private Practice (solo/group/HMO)	☐ Public Health Department Clinic as agent for FQHC/RHC-deputized	☐ Family Planning
☐ Private Practice (solo/groups as agent for FQHC/RHC-deputized)	☐ Public Hospital	☐ Juvenile Detention Center
☐ Community Health Center	☐ FQHC/RHC (Community/Migrant/Rural)	☐ Correctional Facility
☐ Pharmacy	☐ Community Health Center	☐ Drug Treatment Facility
☐ Birthing Hospital	☐ Tribal/Indian Health Services Clinic	☐ Migrant Health Facility
☐ School-Based Clinic	☐ Woman, Infants and Children	☐ Refugee Health Facility
☐ Teen Health Center	☐ Other_____	☐ School-Based Clinic
☐ Adolescent Only Provider		☐ Teen Health Center
☐ Other_____		☐ Adolescent Only

VACCINES OFFERED (select only one box)

☐ All ACIP Recommended Vaccines

☐ Offers Select Vaccines (**This option is only available for facilities designated as Specialty Providers by the VFC Program)**

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g., OB/GYN; STD clinic; family planning) or (2) a specific age group within the general population of children ages 0-18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

☐ DTaP	☐ Meningococcal Conjugate	☐ TD
☐ Hepatitis A	☐ MMR	☐ Tdap
☐ Hepatitis B	☐ Pneumococcal Conjugate	☐ Varicella
☐ HIB	☐ Pneumococcal Polysaccharide	☐ Other, specify:
☐ HPV	☐ Polio	
☐ Influenza	☐ Rotavirus	

PROVIDER POPULATION

Provider Population based on patients seen during the previous 12 months. *Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.*

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian/Alaska Native				
Underinsured in FQHC/RHC or Deputized Facility[1]				
Total VFC:				
Non-VFC Vaccine Eligibility Categories	**# of children who received non-VFC Vaccine by Age Category**			
	<1 Year	**1-6 Years**	**7-18 Years**	**Total**
Insured (private pay/health insurance covers vaccines)				
Other Underinsured[2]				
Children's Health Insurance Program (CHIP)[3]				
Total Non-VFC:				
Total Patients (must equal sum of Total VFC + Total Non-VFC)				

[1]Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.

In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate these underinsured children.

[2]Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.

[3]CHIP – Children enrolled in the state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.

TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)

☐ Benchmarking
☐ Medicaid Claims
☐ IIS
☐ Other (must describe):
☐ Doses Administered
☐ Provider Encounter Data
☐ Billing System

TEXAS WOMEN'S HEALTH PROGRAM CERTIFICATION

TEXAS Health and Human Services Commission

This certification pertains to the following billing or performing provider:

Provider Name _____

Federal Tax ID Number _____

NPI Number _____

Provider's primary billing address:

Street Address _____

Street Address City/State/Zip Code _____

Telephone Number _____

Provider's primary physical address:

Street Address _____

Street Address City/State/Zip Code _____

Telephone Number _____

DEFINITIONS

For the purposes of this certification, as provided for by Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45, the following terms are defined as follows:

The term "affiliate" means:

(A) An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

(i) common ownership, management, or control;

(ii) a franchise; or

(iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark.

The "written instruments" referenced above may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, or a license, but do not include agreements related to a physician's participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

The term "promote" means advancing, furthering, advocating, or popularizing elective abortion by, for example:

(1) taking affirmative action to secure elective abortion services for a Texas Women's Health Program (TWHP) client (such as making an appointment, obtaining consent for the elective abortion, arranging for transportation, negotiating a reduction in an elective abortion provider fee, or arranging or scheduling an elective abortion procedure); however, the term does not include providing upon the patient's request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider;

(2) furnishing or displaying to a TWHP client information that publicizes or advertises an elective abortion service or provider; or

(3) using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

My name is _____. I am the provider or, if the provider is an organization,

I am the provider's (title or position) _____. I am of sound mind, capable of making this certification, and I am personally acquainted with the facts stated here. If I am representing an organizational provider, I am authorized to make this certification on the provider's behalf.

Throughout the remainder of this document, the word "I" will represent the individual provider that is completing this form or the organizational provider on whose behalf the form is being completed. If this form is being completed on behalf of an organizational provider, the word "I" is inclusive of the organizations, owners, officers, employees, and volunteers, or any combination of these.

I understand that, under Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45, I am not qualified to participate in the TWHP, or to bill the program for services if I perform or promote elective abortions, or if I am an affiliate of an entity that performs or promotes elective abortions.

By checking the boxes under each statement below, I affirm that each of the following statements is true. I understand that my failure to mark each of the statements will be regarded as my representation that the statement is false:

1. I do not perform or promote elective abortions outside the scope of the TWHP.

☐ ❒ I affirm that this statement is true and correct.

2. I am not an affiliate of an entity that performs or promotes elective abortions.

☐ ❒ I affirm that this statement is true and correct.

3. In offering or performing a TWHP service, I do not promote elective abortions within the scope of the TWHP.

☐ ❒ I affirm that this statement is true and correct.

4. In offering or performing a TWHP service, I maintain physical and financial separation between my TWHP activities and any elective abortion-performing or abortion-promoting activity, In particular:
   a. All TWHP services are physically separated from any elective abortion activities, no matter what entity is responsible for the activities;
   b. The governing board or other body that controls me has no board members who are also members of the governing board of an entity that performs or promotes elective abortions;
   c. None of the funds that I receive for performing TWHP services are used to directly or indirectly support the performance or promotion of elective abortions by an affiliate, and my accounting records confirm this;
   d. At my location and in my public electronic communications, I do not display any signs or materials that promote elective abortion.

☐ ❒ I affirm that this statement is true and correct.

5. I do not use, display, or operate under a brand name, trademark, service mark, or registered identification mark of an organization that performs or promotes elective abortions.

☐ ❒ I affirm that this statement is true and correct.

In addition, I understand and acknowledge that:

- If I fail to complete and submit this certification, I will be disqualified from the TWHP and the Texas Department of State Health Services (DSHS) or its designee (henceforth, "DSHS") will deny any claims I submit for TWHP services.
- If, after I submit this signed certification, I perform, agree to perform, or promote elective abortions, or I affiliate or agree to affiliate with an entity that performs or promotes elective abortions, I will notify DSHS at least 30 calendar days before I perform or promote an elective abortion or affiliate with an entity that does so. If I fail to notify DSHS as required, I will be disqualified from the TWHP and DSHS will deny any claims I submit for TWHP services.
- If, while participating in the TWHP, I perform or promote an elective abortion, I will be disqualified from the TWHP, and DSHS will deny any claims I submit for TWHP services.
- If I submit this certification and agree to its terms, but DSHS determines that I am in fact ineligible to participate in the TWHP, DSHS may place a payment hold on claims submitted by me or my organization for TWHP services until DSHS can make a final determination regarding my eligibility.
- If DSHS determines that I am ineligible to receive funds under the TWHP:

  a) DSHS may recoup TWHP funds paid on claims that I have incurred since the date the provider became ineligible;

  b) DSHS will deny all TWHP claims that I have submitted since the date of ineligibility; and

  c) I will remain ineligible to participate in the TWHP until I comply with Texas Human Resources Code section 32.024(c-1) and Title 25 of the Texas Administrative Code, Sections 39.31 through 39.45.
- If I knowingly make a false statement or misrepresentation on this certification, DSHS may consider me to have committed fraud or tampered with a government record under the laws of Texas, and I may be excluded from participation in the TWHP.

I also understand that, to enable DSHS to verify my or my organization's eligibility to participate in the TWHP, I must complete and return this certification form to DSHS at the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

If statements 1 – 5 are all marked "true," the effective date of the Certification spans from the date of form completion through the end of the Certification year.

Note: *Each provider must complete a new certification and mail it to TMHP by the end of each calendar year.*

If any of statements 1 – 5 are not true, you must request an immediate termination of your TWHP certification:

☐ ❒ Terminate TWHP Certification

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Appendix B: Useful Information - Please Read

Frequently Asked Questions

Q. How long does it take to process an enrollment application?

A. It takes up to 60 days to process the enrollment application once TMHP has received all of the information that is necessary to process it. It may take longer in special circumstances.

Q. Can I submit a temporary license?

A. TMHP only accepts temporary licenses from physicians and physician assistants.

Q. Do I have to notify TMHP when I receive my full license or when I update my license?

A. Yes. Providers are also required to submit to TMHP, within 10 days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification to continued participation in Texas Medicaid.

Q. Should I send my application by regular or certified mail, or should I send it through an express mail service?

A. Do not send certified mail to TMHP. You can send your application by regular mail, but TMHP recommends using an express service, like FedEx or UPS, so that you have a tracking number, a delivery receipt, and a guarantee of quick delivery. Send express mail to our physical address:

TMHP-Provider Enrollment
12357B Riata Trace Parkway
Austin, TX 78727

Q. How will I receive my new Texas Provider Identifier (TPI)?

A. Notification letters are printed the business day after an application is processed. Notifications are mailed to the physical address listed on the application. New providers will also receive a welcome packet that includes orientation information and other important documents.

Q. Does TMHP supply claim forms?

A. TMHP does not supply CMS-1500, Dental ADA, and UB-04 claim forms. You can buy the forms at any medical office supply store. You can submit claims online for free using TexMedConnect.

Q. Should I wait to submit claims until I receive a TPI?

A. No. Please refer to "Claims Filing and Filing Deadline Information" in this section for more information about claims filing deadlines.

Q. As a Medicaid provider, how long do I have to retain records about the services I render?

A. You must retain records for a minimum of five years from the date of service or until all audit questions, appeal hearings, investigations, and court cases have been resolved. Freestanding rural health clinics (RHCs) must retain records for six years. Hospital-based RHCs must retain records for 10 years. The records retention requirements do not affect any time limits for pursuing administrative, civil, or criminal claims.

Q. How do I update my address, phone number, and other information?

A. You can update your information through your provider portal account on **www.tmhp.com**. Providers can only update some of their information online. All other information must be updated using the Provider Information Change Form. Providers can update the following information online:

- Address, telephone numbers, and office hours
- Languages spoken
- Additional sites where services are provided
- Accepting new patients
- Additional services offered
- Client age or gender limitations
- Counties served
- Medicaid waiver programs

Q. How long is my enrollment active?

A. All providers are enrolled under a limited enrollment as regulated by 42 CFR §455.414, and Title 1 Texas Administrative Code (TAC) §352.5, and §352.9. Providers are required to revalidate their enrollment at least every 3 to 5 years.

Providers must notify TMHP of any changes by submitting the Provider Information Change (PIC) Form which is available on the Forms page of the TMHP website at **www.tmhp.com**.

Claims Filing and Filing Deadline Information

As a potential new provider to Texas Medicaid, you must abide by the applicable claims filing procedures and deadlines as outlined in the current Texas Medicaid Provider Procedures Manual while your Texas Medicaid Provider Enrollment Application is in review by TMHP and HHSC. This is particularly important if you render Medicaid services to clients before you receive your welcome letter with your assigned provider identifier.

There is no guarantee that your application will be approved for processing or that you will be assigned a Texas Provider Identifier (TPI). If you decide to provide services to a Medicaid client before your application has been approved, you do so with the understanding that, if your application is denied, Texas Medicaid will not pay the claims and that the law also prohibits you from billing the Medicaid client for the services that you provided.

If you render services to Medicaid clients before you receive your TPI, you must follow the claims filing procedures and meet the filing deadlines that are specified in the most current *Texas Medicaid Provider Procedures Manual*.

All claims for services rendered to Medicaid clients who do not have Medicare benefits are subject to a filing deadline from date of service of:

- 95 days of the date of service on the claim
- 365 days for OUT-OF-STATE providers or from the discharge date for inpatient claims

Providers who render services to a Medicaid client before they complete the enrollment process and receive a TPI must submit claims within the following deadlines:

- Newly enrolled providers:
  - TMHP must receive claims that were submitted by instate providers and providers located within 50 miles of the Texas state border within 95 days of the date on which the new provider identifier was issued.
  - TMHP must receive the claims within 365 days of the date of service (DOS) (i.e., the date on which the service was provided or performed).
- Newly enrolled clients:
  - TMHP must receive the claims within 95 days of the date on which the client's eligibility was added to the TMHP eligibility file (i.e., the "add date").
  - TMHP must receive the claims within 365 days of the DOS for professional or outpatient claims or within 365 days of the discharge date for inpatient claims.
- Clients with retroactive eligibility:
  - TMHP must receive the claims within 95 days of the date on which the client's eligibility was added to the TMHP eligibility file (i.e., the "add date").
  - TMHP must receive the claims within 365 days of the DOS for professional or outpatient claims or within 365 days of the discharge date for inpatient claims.
- Clients with dual Medicare and Medicaid eligibility:
  - When the rendered service is a benefit of Medicare and Medicaid, the claim must be submitted to Medicare first. TMHP must receive the claim for Medicaid's portion of the payment within 95 days of the date of the Medicare disposition.
  - When a client is only eligible for Medicare Part B, the inpatient hospital claim is sent directly to TMHP. TMHP must receive the inpatient claim within 95 days of the date of discharge.

Note: *TMHP only processes one client per Medicare RA. For multiple clients, submit one copy per client.*

The Texas Administrative Code (TAC), Code of Federal Regulations, and Texas Health and Human Services Commission (HHSC) established these deadlines.

Therefore, providers must submit all claims for services that have been provided to Medicaid clients to the following address within the 95-day filing deadline.

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal. Procedures for appealing denied or rejected claims are included on the Remittance and Status (R&S) report that is available for download at **www.tmhp.com** and in the claims filing section of the *Texas Medicaid Provider Procedures Manual*.

Limited ("Lock–In") Information

Clients are placed in the Limited Program if, on review by HHSC and the Office of Inspector General (OIG), their use of Medicaid services shows duplicative, excessive, contraindicated, or conflicting health care and/or drugs; or if the review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services. Clients qualifying for limited primary care provider status are required to choose a primary care provider. The provider can be a doctor, clinic, or nurse practitioner in the Medicaid program. If a limited candidate does not choose an appropriate care provider, one

is chosen for the client by HHSC/OIG after obtaining an agreement from the provider. The provider is responsible for determining appropriate medical services and the frequency of such services. A referral by the primary care provider is required if the client is treated by other providers.

Change of Ownership

Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and HHSC, a change of ownership of a facility does not terminate Medicare eligibility. Therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements:

1. Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
2. Complete new Medicaid provider enrollment packet.
3. Provide TMHP with copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners).
4. Give a listing of ALL provider identifiers affected by the change of ownership.
5. Complete and submit the CHOW Questionnaire and Statement.

Written Communication

Enrollment Applications:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

Claims:

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Telephone Communication

CCP Provider Customer Service.....1-800-846-7470

TMHP Contact Center 1-800-925-9126

TMHP EDI Help Desk.....1-888-863-3638