

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Supplemental Services
Provider Enrollment Application

1. Action Requested:

Check "Initial Enrollment (New)" if you are:

- a. requesting enrollment as a new provider;
- b. expanding your enrollment to include a new or additional specialty type for a supplemental service;
- c. requesting to open a new service location (including a satellite location)

Check "Service Location Change" if:

- a. you have an existing PROMISe™ service location and you have moved to a new physical location

Check "Fee Assignment" if you are:

- a. Adding this provider to an existing provider group. Fee Assignment may only be made between "like provider types". If enrollee is a Group, attach a copy of your Corporation Papers

2. Enrollee's Name:

List the applicant's name (individual practitioner, facility or group) and date of birth (if applicant is an individual). If operating under a fictitious business/doing-business-as (dba) name, attach copy of recorded/stamped fictitious business name statement/permit.

3. Tax Identification Information (TIN):

List the enrollee's Social Security Number (SSN) or Federal Employer Identification Number (FEIN). Enclose verification of the TIN with your application (e.g., a copy of Social Security card, W-2 or a copy of an IRS-generated document containing the IRS number and name. **Note: A W-9 is not acceptable proof of tax ID.**)

Enter the legal name as shown on the tax ID, and the corresponding current address, telephone and fax numbers and contact information. **(Note: Do not list tax information of entity to which payment will be made if said entity is not the enrollee.)**

4. National Provider Identifier (NPI) #:

List your 10 digit NPI # and taxonomy(s). Include a copy of your NPPES confirmation letter verifying your NPI #.

5. Business Type:

Check the appropriate box for your business type (check one box only). Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.

6. BH-MCO:

Identify the BH-MCO with the network in which participation will occur.

7. Counties You Are Approved to Serve:

List each county you are approved to serve.

8. Supplemental Services:

Check the type of supplemental service(s) for which you are applying. As noted, attach a copy of your License/Certificate of Compliance or your tailored Supplemental Service Description (SSD) and the OMHSAS approval letter of your SSD, if applicable

9. Population to be Served:

Check the appropriate box(es) to denote the age group(s) of the consumers you will be serving.

10. Confidential Information:

The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions. If "Yes" is answered to any of the questions, provide a detailed explanation and include it with your completed enrollment application.

11. Physical Service Location:

List the physical address where services will be provided. A Post Office Box is not a valid service location. Complete a separate Page 5 of the application for each intended physical service location.

12. Mail To Information:

Indicate the address of where you want correspondence to be mailed. (e.g. notification of enrollment)

13. Pay To Information:

Indicate address of where payments will be sent. Payments will be initiated via the BH-MCO.

14. Home Office Information:

Indicate the entity's headquarters address.

15. Sign and date the application, print your name and list your telephone number. The signature should be that of the individual applying for enrollment, or someone able to represent the facility applying for enrollment. Use black ink.

Additional Required Forms: - Forward completed application to the Behavioral Health Managed Care Organization (BH-MCO) with which you are affiliated. Also include as applicable:

- One DPW Outpatient Provider Agreement with original signature.
- Copy of Department of Health Certificate Licensure, Department of Public Welfare Certificate of Compliance, Department of State Licensure or a tailored service description.
- Copy of OMHSAS letter denoting SSRC approval of the tailored service description.
- Verification of Tax ID name and number.
- Separate page 5 of application for each additional location where services will be provided.
- Completed Ownership or Control Interest Forms

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
HealthChoices Behavioral Health Supplemental Services
Provider Enrollment Application

For OMHSAS Internal Use Only

PROMISe ID _____ / _____

1. Action Requested - Check Boxes That Apply:

- Initial Enrollment (New) Individual Facility Group
- Service Location Change (include Service Location Change Form to close old location)
- Fee Assignment – Add this provider to an existing provider group
Specify group PROMISe™ provider number:

_____ (Must be a 13 digit number)

2. Enter Name of Enrollee:

Facility Name:

Or

Last Name: _____ First: _____ Middle: _____

Date of Birth: ____/____/____ Ex: (2012/xx/xx) Gender: Male Female

3. Tax Identification Information

Social Security Number: _____ - _____ - _____

*A copy of the document generated by the IRS that includes your name and SSN must accompany this application.

Federal Tax ID Number: _____ - _____

*A copy of the document generated by the Federal IRS with the name and IRS number must accompany this application.

Legal Name (must be same as denoted on tax ID): _____

Address: _____

City: _____ County: _____ State: _____ Zip Code (9 digit) _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Contact Name/Title: _____ Contact e-mail: _____

4. National Provider Identifier (NPI) #: _____

*A copy of the NPPES confirmation letter must be attached

Taxonomy(s): (10 digits) _____

5. Business Type:

- Corporation Not-for-Profit Government Owned Partnership
 Estate/Trust Sole Proprietorship

(Include corporation papers or business partnership agreement, if applicable)

6. Behavioral Health Managed Care Organization (BH-MCO):

Identify the BH-MCO with the network in which participation will occur.

7. Counties You Are Approved to Serve:

8. Supplemental Services: Check the service(s) below for which you are applying. Attach a copy of the required document(s) as identified below.

Residential and Housing Support Services – Department of Public Welfare Certificate of Compliance

Adult Residential Treatment Facility PT/PS 11/110

Rehabilitative & Day Treatment Program Services – Department of Public Welfare Certificate of Compliance

Psychiatric Rehabilitation Site Based Mobile Clubhouse PT/PS 11/123

Outpatient - Drug & Alcohol – Department of Health Drug & Alcohol Certificate of Licensure

D&A Intensive Outpatient (IOP) PT/PS 11/128

D&A Outpatient in an Alternative Setting PT/PS 11/184

Drug & Alcohol Inpatient Non-Hospital – Department of Health Drug & Alcohol Certificate of Licensure

Drug-Free Halfway PT/PS 11/131

Detoxification PT/PS 11/132

Drug-Free Residential, Short Term PT/PS 11/133

Drug Free Residential, Long Term PT/PS 11/134

Drug & Alcohol Partial Hospitalization – Department of Health Drug & Alcohol Certificate of Licensure

Methadone Maintenance PT/PS 11/129

Drug-Free PT/PS 11/129

Drug and Alcohol Behavioral Health

D&A Outpatient Practitioner Department of Health Certificate of Licensure & Appropriate State Licensure PT/PS 11/127

D&A Services – Other SSD and FO SSRC approval letter PT/PS 11/184

D&A Intervention SSD & Field Office Attestation PT/PS 11/184

D&A Level of Care Assessment SSD & Field Office Attestation PT/PS 11/184

D&A Intensive Case Management SSD & Field Office Attestation PT/PS 21/138

D&A Resource Coordination SSD & Field Office Attestation PT/PS 21/138

Mental Health General

BSU Diagnostic Assessment SSD & Field Office Attestation PT/PS 11/110

Community Treatment Teams SSD and FO SSRC approval letter PT/PS 11/111

Assertive Community Treatment (ACT) Requires SSD and SSRC approval & Dept of Public Welfare Certificate of Compliance PT/PS 11/111

MH Outpatient Practitioner Requires appropriate state licensure PT/PS 11/112

Community MH Services, Other SSD and FO SSRC approval letter PT/PS 11/119

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9. Population to be Served:

Children (ages 0-12) Adolescents (13-17) Adults (18-64) Elderly (65 and up)

10. CONFIDENTIAL INFORMATION

Have you or any director, officer, manager, consultant, agent, employee, or volunteer of your Organization/facility:

Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

Yes No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

Yes No

Had a controlled drug license withdrawn?

Yes No

Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

Yes No

In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

Yes No

If you answered "Yes" to any of the questions above, provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated, and attach it to your application. Include the following information as applicable to the situation:

- | | |
|--|--|
| 1. Name and title of individual | 8. Disposition/State |
| 2. Name of federal or state health care program | 9. Date license was surrendered |
| 3. Name of licensing/certifying agency taking the action | 10. Name of court |
| 4. Date of action | 11. Date of conviction |
| 5. Type of action taken | 12. Offense(s) convicted of |
| 6. Length of action | 13. Sentence(s) |
| 7. Basis for action | 14. Categorization of offense
(e.g., felony, misdemeanor) |

11. Physical Service Location:

Same as Legal Entity Address (on pg. 1)

 Street (Note: List physical street address. A PO Box is not acceptable.)

 City State Zip (9 digit) County

(____) _____ - _____
 Phone E-mail

12. Mail To Information:

Same as Service Location Same as Legal Entity Address (on pg. 1)

 Street

 City State Zip (9 digit) County

(____) _____ - _____
 Phone E-mail

13. Pay To Information:

Same as Service Location Same as Legal Entity Address (on pg. 1) Same as Mail To

 Street

 City State Zip (9 digit) County

(____) _____ - _____
 Phone E-mail

14. Home Office Information:

Same as Service Location Same as Legal Entity Address (on pg. 1) Same as Mail To
 Same as Pay To

 Street

 City State Zip (9 digit) County

(____) _____ - _____
 Phone E-mail

15.

 Provider's Signature Printed Name Telephone Date

**Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Supplemental Services**

PROVIDER AGREEMENT FOR OUTPATIENT PROVIDERS

1. This is to certify that _____ agrees to participate in the Pennsylvania Medical Assistance Program on the following terms:
2. The provider shall comply with all applicable State and Federal laws, regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
3. Specifically, and without limitations, the provider shall:
 - a. Keep any records necessary to disclose the extent of services the provider furnishes to recipients;
 - b. Upon request, furnish to the Department of Public Welfare, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under paragraph (a) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program; and
 - c. Comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
4. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State laws and regulations.

By: _____
Original Signature of Provider (No Stamp)

Printed Name of Provider

Date

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following forms. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please print and attach additional sheets.

Definitions

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner), or a fiscal agent. Any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act means:

- a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Individual practitioner means a physician or other person licensed or certified under State Law to practice his or her profession.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

- a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c. Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

- e. An officer or director of a disclosing entity that is organized as a corporation; or
- f. Is a partner in the disclosing entity that is organized as a partnership

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

- a. 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
- b. 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, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

If you are a non-profit organization, please skip this section and complete Attachment II.

Ownership or Control Interest

Note: Ownership information is required in accordance with Federal Regulation 42 CFR, Part 455, published July 17, 1979.

Please enter the full name and address of partners, stockholders, corporate owners, or officers that have at least 5% direct or indirect ownership interest. Attach additional sheets, if necessary.

Complete below for **Individuals**:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Ownership or Control Interest (continued)

Complete the below for **Corporate Entities**:

The address for each corporate entity **must** include: primary business address, every business location, and P.O. Box address – Attach additional sheets, if necessary.

Name of Corporation	-	FEIN/Tax ID Number
Street Address		PO Box
City	State	Zip Code

.....

Name of Corporation	-	FEIN/Tax ID Number
Street Address		PO Box
City	State	Zip Code

.....

Name of Corporation	-	FEIN/Tax ID Number
Street Address		PO Box
City	State	Zip Code

.....

Name of Corporation	-	FEIN/Tax ID Number
Street Address		PO Box
City	State	Zip Code

.....

Ownership or Control Interest (continued)

Please enter the full name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more. Attach additional sheets, if necessary.

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____/_____/_____
Date of Birth _____ Street Address _____

City _____ State _____ Zip Code _____

Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? Yes* No * If "Yes", please attach details.

.....

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____/_____/_____
Date of Birth _____ Street Address _____

City _____ State _____ Zip Code _____

Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program? Yes* No * If "Yes", please attach details.

.....

Are any of the aforementioned persons related to each other as a spouse, parent, child, or sibling? If so, please list the names of the individuals and how they are related.

Names: _____ Relationship: _____

Names: _____ Relationship: _____

Names: _____ Relationship: _____

Ownership or Control Interest (continued)

Do you or any of the aforementioned individuals have a controlling interest in, or own other providers of services? Yes* No *If "Yes", list the name and address of each provider.

Name: (First) _____ (Middle) _____ (Last) _____

Street Address _____

City _____ State _____ Zip Code _____

Name of individual with ownership or control interest _____

Name: (First) _____ (Middle) _____ (Last) _____

Street Address _____

City _____ State _____ Zip Code _____

Name of individual with ownership or control interest _____

Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period? Yes* No *If "Yes", give the information below for each wholly owned supplier or subcontractor. Attach additional sheets, if necessary

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

/ / _____
Date of Birth Street Address _____

City _____ State _____ Zip Code _____

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

/ / _____
Date of Birth Street Address _____

City _____ State _____ Zip Code _____

Managing Employee or Agent Disclosure Form

A. Please provide the name, address, social security number, and date of birth of any person who is an agent or managing employee of the provider

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____/_____/_____/_____
Date of Birth Street Address
City State Zip Code

.....

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____/_____/_____/_____
Date of Birth Street Address
City State Zip Code

.....

B. Please provide the name and description of offense of any person who is an agent or managing employee and has been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program.

Name: (First) _____ (Middle) _____ (Last) _____
Description of offense

.....

Name: (First) _____ (Middle) _____ (Last) _____
Description of offense

.....

Name: (First) _____ (Middle) _____ (Last) _____
Description of offense

.....

Non-Profit Disclosure

Please add anyone who has a controlling interest or is a board member

President:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Vice President:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Secretary:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Treasurer:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____
_____-_____-_____
Date of Birth Street Address

City State Zip Code

Other:

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

 / / _____
 Date of Birth _____ Street Address _____

 City _____ State _____ Zip Code _____

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

 / / _____
 Date of Birth _____ Street Address _____

 City _____ State _____ Zip Code _____

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

 / / _____
 Date of Birth _____ Street Address _____

 City _____ State _____ Zip Code _____

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

 / / _____
 Date of Birth _____ Street Address _____

 City _____ State _____ Zip Code _____

Name: (First) _____ (Middle) _____ (Last) _____ Social Security Number _____

 / / _____
 Date of Birth _____ Street Address _____

 City _____ State _____ Zip Code _____

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Supplemental Services
Fee Assignment Form for Group Members Instructions

Date: enter today's date

Group 13-Digit Provider ID: enter the 13-digit provider ID of the group you want to assign payment to

Group Name: enter the group name

Contact Name: enter a contact name that can be contacted for any questions related to this enrollment

Contact Phone: enter the phone number of the above contact person

This form can be used for up to five individual practitioners assigning payment to the same group. Each individual practitioner assigning payment must enter their printed name, 13-digit provider id number and effective date to be used for assigning payment to the group. The individual practitioner must also sign the form. Stamped signatures are not acceptable.

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Supplemental Services
Fee Assignment Form for Group Members

Date: _____

Group 13-Digit Provider ID: _____

Group Name: _____

Contact Name: _____

Contact Phone: (____) _____ - _____

Note: By signing, I am agreeing to assign my fees to the Group and Service Location, listed above.

1. _____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)

_____ _____
13 Digit Individual Provider Number Effective Date

2. _____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)

_____ _____
13 Digit Individual Provider Number Effective Date

3. _____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)

_____ _____
13 Digit Individual Provider Number Effective Date

4. _____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)

_____ _____
13 Digit Individual Provider Number Effective Date

5. _____
Printed Name of Individual Provider Assigning Payment Original Signature of Individual Provider Assigning Payments (No Stamp)

_____ _____
13 Digit Individual Provider Number Effective Date