

# NOT TO BE COMPLETED BY PHYSICIAN ASSISTANTS

## Introduction

As a Medicaid and other programs provider you must be enrolled and re-certified. If you are required to be licensed in your state you must attach a copy of your license. If your state does not require a license or certification for the service you provide, certification will be verified through the EDS office.

Please find enclosed your Provider Agreement.

Please complete ALL of the data sheets in Attachment B. These sheets must be completed and the agreement (on page 2) must be signed and dated in order for your agreement with the Department to be considered in effect.

Section 10 of Attachment B addresses controlling interests. Completing this information correctly is a Medicaid Program integrity requirement and must be provided before you may be enrolled as a provider. If a group practice, or a corporation employs you or a facility owns your practice you must list the name of that entity in section 10. If you have any questions, please contact the EDS Provider Enrollment Unit at (802)-878-7871) or (800-925-1706)(toll free if you are calling in Vermont).

## **FORM REVISED 7/08**

ELECTRONIC DATA SYSTEMS  
ENROLLMENT/RECERTIFICATION  
P.O. BOX 888  
WILLISTON, VT 05495-0888

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EDS USE ONLY
Date Sent:
Date Received:

**AGENCY OF HUMAN SERVICES - OFFICE OF VERMONT HEALTH ACCESS  
PROVIDER ENROLLMENT/RECERTIFICATION AGREEMENT**

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

THE UNDERSIGNED AGREES TO BE BOUND BY THE PROVISIONS OF THIS AGREEMENT:

If the provider is a facility or group, the provider also attests that the undersigned is authorized to act for the entity.

By the PROVIDER

Date: \_\_\_\_\_ Mandatory

Name: (Please Print Name) \_\_\_\_\_

Signature: \_\_\_\_\_ Mandatory (has to be original – stamp or copy not allowed)

Title: \_\_\_\_\_

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## ATTACHMENT A

### CONDITIONS OF PARTICIPATION

Provider agrees to the following:

- 1 To conform to all applicable Federal and State laws and regulations including Title VI of the 1964 Civil Rights Act, the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act.
- 2 To be licensed, certified or registered with the appropriate State authority.
- 3 To comply fully with the instructions and restrictions regarding billing and third-party payments set out in the pertinent Provider Manual including its supplements. The Manual and Supplements are available on the web at [www.vtmedicaid.com](http://www.vtmedicaid.com) and also in paper form on request to EDS Provider Services Unit. The Manual and Supplements are incorporated by reference herein.
- 4 To maintain and make available for inspection all medical, case or business records pertaining to the extent of services provided and any other information regarding payments, claimed or received, as they may pertain to the Office of Vermont Health Access programs. Additionally, the provider agrees to furnish these records and the other specified information to the Vermont Agency of Human Services, the U.S. Secretary of Health and Human Services and the Office of the Vermont Attorney General. Such records shall be retained for seven (7) years.
- 5 To verify the eligibility of each patient, prior to providing the service, for each date of service, except where EMTALA applies.
- 6 To file a complete and accurate claim in a timely fashion. The signature of the provider, or the provider's designee, on a paper claim or the signature on the transmittal agreement for electronic claims, certifies that the service(s) listed was medically necessary and actually rendered to a state health care program beneficiary. The provider is solely responsible for the accuracy of claims submitted, whether in paper or electronic form.
- 7 If the provider will not accept Medicaid payment for a service, to give notice to the Medicaid beneficiary in advance of providing the service.
- 8 To establish and maintain a uniform charge for each item or service provided under this agreement.
- 9 To accept the state health care program payment for any service or item, as payment in full, and to make no additional charge to a beneficiary except as allowed under the Provider Manual or PATH rules.
10. To receive payment for services through Electronic Funds Transfer (EFT).

**ATTACHMENT B**

**PROVIDER IDENTIFICATION RECORD**

**SECTION 1 – PROVIDER DATA**

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

UPIN Number: \_\_\_\_\_ License/Cert #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ CLIA Number: (**LAB ONLY**) \_\_\_\_\_ Exp. Date: **LAB ONLY**

NABP Number: (**PHARMACY ONLY**) \_\_\_\_\_ DEA Number: (**IF PRESCRIBING**) \_\_\_\_\_ Fiscal Year End Month: \_\_\_\_\_

VT Medicaid Number: \_\_\_\_\_ SSN or FEIN #: \_\_\_\_\_  SSN  FEIN #  
(SSN for individuals, and FEIN for groups/ institutions)

**NPI** (Attach copy of official NPI letter)

Taxonomy Code \_\_\_\_\_

Gender of Provider: \_\_\_\_\_

**SECTION 2 – CONTACT INFORMATION**

CONTACT PERSON (**Who to contact regarding this form**) \_\_\_\_\_ PHONE **Contact person phone** \_\_\_\_\_

FAX **Contact person Fax** \_\_\_\_\_

**SECTION 3 - PROVIDER ADDRESS INFORMATION**

**PAY TO (For Remittance Advice)**

Name: \_\_\_\_\_

Address: **Your RA will be mailed to this address**

City: \_\_\_\_\_

State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Fax: \_\_\_\_\_

SEC. 3 CNTD. SERVICE ADDRESS & DEMOGRAPHIC INFORMATION

If you have more service locations than listed here, please include them on an additional sheet of paper. You MUST answer the same questions given below with information specific to each additional service location. If the service location(s) listed here is/are no longer valid please cross it out but leave the sheet attached!

Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Address: **(Physical Location cannot be a PO Box)**  
\_\_\_\_\_

City: \_\_\_\_\_

State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Handicap Accessibility of this service location:**

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

**Languages Accommodated at this office:**

English, (e.g. Bosnian, French, Sign, etc) \_\_\_\_\_

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

- All ages
- Newborn
- Age Range: \_\_\_ youngest \_\_\_ oldest

**Are you accepting new patients?:**  Yes

No

**Provider Fax Number:** \_\_\_\_\_

**Provider Email Address:** \_\_\_\_\_

**Provider/Office Website:** \_\_\_\_\_

**SECTION 3 CNTD - PROVIDER ADDRESS INFORMATION**

<p><b>LEGAL ADDRESS</b> (This is the name and address that will appear on your 1099)</p> <p>Name: _____</p> <p>Address: <b>This is the name and address that will appear on your 1099 for IRS</b></p> <p>City: _____</p> <p>State, Zip: _____</p> <p>Phone: _____</p> <p>Email Address: _____</p> <p>Fax: _____</p>	<p><b>MAIL TO ADDRESS</b> (For correspondence and newsletters)</p> <p>Name: _____</p> <p>Address: <b>Complete of different than PAY TO</b></p> <p>City: _____</p> <p>State, Zip: _____</p> <p>Phone: _____</p> <p>Email Address: _____</p> <p>Fax: _____</p>
<p><b>PRIOR AUTHORIZATION ADDRESS</b> (If your service location has no mail receptacle)</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State, Zip: _____</p> <p>Phone: _____</p> <p>Email Address: _____</p> <p>Fax: _____</p>	<p><b>BILLING SERVICE</b></p> <p>Name: _____</p> <p>Address: <b>Complete if applicable</b></p> <p>City: _____</p> <p>State, Zip: _____</p> <p>Phone: _____</p> <p>Email Address: _____</p> <p>Fax: _____</p>

**SECTION 4 - MEDICAL OR CLINICAL SPECIALTIES**

<b>SPECIALTY</b>	EFFECTIVE DATE	BOARD CERTIFIED	DATE OF CERTIFICATION
<b>Please complete)</b>		<b>YES</b> _____ <b>NO</b> _____	
		YES _____ NO _____	

**\*\*All applicants who are physicians, nurse practitioners, dentists, doctoral-level psychologists & social workers, or individual DME providers (prosthetics) must complete this section if applicable.\*\***

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

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

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**(Please check one)**

2. Applicant's type of business:

- |  |  |
|--|--|
| <input type="radio"/> Individual             | <input type="radio"/> Corporation Non-Profit |
| <input type="radio"/> Corporation for Profit | <input type="radio"/> Sole Proprietor        |
| <input type="radio"/> Partnership            | <input type="radio"/> Other, specify _____   |

SECTION 6 - SUSPENSION AND DEBARMENT

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

Providers may not knowingly have a relationship with the following:

An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

SECTION 7 - TERMINATION/CONVICTION/SANCTION INFORMATION

Answer the following, as required by state regulations. Have either you or any employee or person in whom you have a controlling interest, or any person having a controlling interest in you, been convicted of a crime related to, or terminated from federal or state medical assistance programs? Have either you or any employee been suspended or disciplined either in this or some other state?

- |                              |                              |
|------------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| <input type="checkbox"/> No  | <input type="checkbox"/> No  |

**If yes, explain**

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**Please answer both questions**

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**SAMPLE**

**SECTION 8 - CONTROLLING INTEREST**

Do you, the applicant, have a controlling interest (see above) in any of the entities listed below, or does any entity listed below have a controlling interest in your practice? **You must check yes or no to each entity or your application will not be complete. If yes, please complete the section(s) on the next page.**

Type of Entity	<b>You</b> have a controlling interest in it.	<b>It</b> has a controlling interest in your practice.
Clinical Laboratory Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech and language therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational therapy services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiology services including MRI and other imaging	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiation therapy services and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Durable medical equipment and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parenteral and enteral nutrients, supplies or equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prosthetic, orthotics, prosthetic devices and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home health services of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy or prescription services (e.g., mail order)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital services of any kind including outpatient services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Group practice</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physicians Health Organization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the group practice you work for is  
Owned by a corporation or facility you  
Must check YES

If you are a partner in a group practice  
You must check YES on both sides

If you are employed  
by a group practice  
you must check YES

**Definition for Section 8**

Controlling Interest – Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 10 percent or greater of outstanding stock, or holders of any other such position or relationships who may have a bearing on the operation or administration of a medical services-related business.

Name **Enter employer's name if applicable**

Medicaid Provider Number (s) **EMPLOYER #** \_\_\_\_\_ SSN/EIN \_\_\_\_\_

Address **Employer's address** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Telephone: Business \_\_\_\_\_ Home \_\_\_\_\_

**Type and percentage of controlling interest or ownership** \_\_\_\_\_

Name \_\_\_\_\_

Medicaid Provider Number (s) \_\_\_\_\_ SSN/EIN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Telephone: Business \_\_\_\_\_ Home \_\_\_\_\_

Type and percentage of controlling interest or ownership \_\_\_\_\_

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

- Yes
- No

If yes, please enter the number \_\_\_\_\_

\*If there are additional entries, please copy this page as needed.

Section 8 continued

Please indicate employer's name in this section. Any employer has a controlling interest in the services you provide.

SECTION 9 - **INSTITUTIONAL INFORMATION**

**NUMBER OF BEDS:** \_\_\_\_\_ **NUMBER OF SWING BEDS:** \_\_\_\_\_

(This information is mandatory for all hospitals.) **NUMBER OF LICENSED BEDS:** \_\_\_\_\_



**\*\* ATTACH A COPY OF THE OFFICIAL NPI LETTER**

**AND**

**\*\* ALSO ATTACH A COPY OF CURRENT LICENSE**

**\*\*PLEASE REVIEW APPLICATION FOR COMPLETENESS – ALL QUESTIONS MUST BE ANSWERED. N/A IS NOT ACCEPTABLE. THE FORM WILL BE RETURNED TO YOU IF NOT ACCURATELY COMPLETED**

**\*\* ORIGINAL SIGNATURE IS A MUST. THIS IS A LEGAL DOCUMENT.**