State of Missouri

Department of Social Services

Missouri Medicaid Audit & Compliance

ENROLLMENT APPLICATION

LIMITED ENROLLMENT FOR ORDERING, PRESCRIBING OR REFERRING (OPR)

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

- In accordance with the implementation of Section 6405 of the Affordable Care Act, the completion of this application is only applicable to physicians and non-physician practitioners enrolling in the Medicaid program for the sole purpose of ordering, prescribing or referring items or services for Medicaid participants.

- These physicians and non-physician practitioners **do not and will not send claims to Medicaid** for the services they provide.

- This type of enrollment does not allow Medicaid to reimburse you for your services.

- Please type or print legible using BLACK OR BLUE INK ONLY.

- Please retain a copy of this entire document for your records.

- Fax the enrollment application and required attachments in one transmission to **573-634-3105.** Faxed pages go directly to the Provider Enrollment database, not an actual fax machine. Only one application and it's attachments are accepted per transmission.

- Questions regarding this enrollment should be submitted to: MMAC.ProviderEnrollment@dss.mo.gov.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
PROVIDER ENROLLMENT APPLICATION FOR ORDERING, PRESCRIBING OR REFERRING **(OPR)** PROVIDERS

Section I: Provider General Information

Provider Name:(Last, First):

NPI Number: | **DEA Number (if applicable):**

Provider Date of Birth: | **Social Security Number:**

Practice Address:

Mailing Address :

Telephone Number: | **Fax Number:**

Provider E-mail address:

Section II: License/Certification Information: List all professional licenses or certifications for all states, add additional pages if more space is needed

License Number	Issuing State	Effective Date	End Date

Section III: Medical Specialties

Physician Specialties If you are a physician, designate your specialties. Select specialties that apply. A physician must meet all federal and state requirements for specialties checked.

Specialty: Select Specialty | Select Specialty

Select Specialty | Select Specialty

Other :

Non Physician Specialties: If you are a non-physician practitioner, check the appropriate box to indicate your specialty. Check only one. All non-physician practitioners must meet specific licensing, educational, and work experience requirements.

Specialty: Select Specialty **Other:**

Section IV: Contact Person Information

If questions arise during the processing of this application, MMAC will attempt to contact you directly at the location listed in Section 1. If you are not available, you may designate a credentialing specialist or alternate contact person below.

Note: The contact person reported in this section will only be authorized to discuss issues concerning this application and enrollment as a provider with MO HealthNet.

Name:

Address:

Telephone Number: | Fax Number:

E-mail address:

Relationship or Affiliation to you:

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PROVIDER ENROLLMENT APPLICATION (OPR)

COMPLETING THIS APPLICATION AS AN INDIVIDUAL PROVIDER, YOU SHOULD ANSWER THE QUESTIONS FOR YOURSELF IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY, MUST BE COMPLETED. INCLUDE ADDITIONAL SHEETS AND/OR ATTACHMENTS IF NECESSARY.

1. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

2 . Has the applying provider, any managing employee, or any person having an ownership or control interest for the applying provider; ever had ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement, other otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

3. Has the license of the applying provider, any managing employee, or any person having an ownership or control interest; ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state? Yes ☐ No ☐
If yes, explain:

4. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any outstanding criminal fines, restitution orders, or overpayments in Missouri or ANY other state? Yes ☐ No ☐
If yes, explain:

8. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been convicted of a crime, excluding minor traffic citations? Yes ☐ No ☐
If yes, list conviction(s), when, and where:

9. Are there any criminal proceedings, restitution orders, or overpayments currently pending for the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's clinic, group, corporation or any other association? Yes ☐ No ☐
If yes, list pending changes and location:

10. Is the applying provider, any managing employee, or any person having an ownership or control interest; related, including but not limited to, a spouse, parent, child, sibling, etc., to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime pertaining to health care services? Yes ☐ No ☐
If yes, list conviction, date and location:

11. Does the applying provider have any pending enrollment applications with any other state or federal program, other than this application? Yes ☐ No ☐
If yes, list state and program:

12. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any pending complaint investigations being reviewed by any professional boards? Yes ☐ No ☐
If yes, explain:

13. Does the applying provider, any managing employee, or any person having ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments to Medicare, Medicaid, or any other federal/state health care programs?
Yes ☐ No ☐ If yes, explain:

14. Does the applying provider now hold a certificate to dispense controlled substances from the federal Drug Enforcement Agency (DEA), the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD), or any other state?
Yes ☐ No ☐ If yes, list all states, certificate numbers, AND #15 MUST BE COMPLETED.

DEA Number: BNDD Number:
DEA Number: BNDD Number:

15. Has the DEA or BNDD certificate ever been suspended, revoked, surrendered, or in any way restricted by probation or agreement? Yes ☐ No ☐
If yes, explain with date, state, city, county, and included attachments.

☐ By checking this block, I certify that I have reviewed the federal and state disclosure regulations for all applying Medicaid providers which are attached to this enrollment application. I also certify that all individuals and/or business organizations with direct or indirect ownership, management and/or control interests have been fully disclosed.

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Department of Social Services. I also understand that pursuant to 13 CSR 65-2, I must advise the Department, in writing, of any changes affecting the provider's enrollment record.

Signature of Applying Provider:	**Date signed:**
Name of Applying Provider:	**Title:**

Please fax your completed application and any supporting documentation to our automated fax system: 573-634-3105

Questions regarding this enrollment packet should be submitted to MMAC.Providerenrollment@dss.mo.gov

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS) – MEDICAID AUDIT AND COMPLIANCE (MMAC)
TITLE XIX PARTICIPATION AGREEMENT MO HEALTHNET PROVIDERS

BY MY SIGNATURE BELOW, I, THE APPLYING PROVIDER, READ AND AGREE THAT, upon the acceptance of my enrollment, I will participate in the Managed Care Organization process or Vendor Payment plan for Medicaid Services as it pertains to my enrollment. I am responsible for all services provided and all billing done under my provider number regardless to whom the reimbursement is paid. It is my legal responsibility to ensure that the proper billing code is used and indicate the length of time I actually spend providing a service regardless to whom the reimbursementis paid. I agree to be financially responsible for all services which are not documented. I agree the Missouri Title XIX Medicaid manual, bulletins, rules, regulations and amendments thereto shall govern and control my delivery of service, and further agree to thefollowing terms:

1. I agree that it is my responsibility to access manual materials that are available from DSS/MMAC over the Internet. I will comply with the Medicaid manual, bulletins, rules, and regulations as required by the DSS/MMAC and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation I am not entitled to Medicaid reimbursement if I fail to so comply, and that I can be terminated from the program for failure to comply;
2. The rate of reimbursement for services will be based on charges established and determined by the DSS/MMAC Medicaid manual, bulletins, and amendments thereto in accordance with the Vendor Payment Program, and that charges will not exceed those to the general public for the same services;
3. I agree that the selection of an electronic or Internet claim processing method in no way modifies any requirements of the Missouri Medicaid program policies or procedures except those dealing with claim submission. I understand that all data elements required by DSS/MMAC for paper claims are required for claims submitted electronically, and that those claims not meeting required specifications will not be processed. In the event that DSS/MMAC places me on prepayment review , as authorized by State Regulation 13 CSR 70-3.030, or on a closed-end agreement, I agree to submit all claims on paper until notified by DSS/MMAC that electronic or Internet billing can resume;
4. I understand that I cannot collect for Title XIX covered services from the recipient-patient, his or her spouse, parent, guardian, relative or anyone else receiving public assistance, and if any payment is received or assured from any other source on the recipient-patient's account, that amount will be deducted from the claim I filed with Title XIX Medicaid. I also understand that I must report any payment so received after provider payment is made by Title XIX to the DSS/MMAC for appropriate adjustment action;
5. I agree that I and any contractor, employees, or subcontractors of mine, shall comply with all applicable provisions of State and Federal laws and regulations pertaining to nondiscrimination, sexual harassment and equal employment opportunity including, but not limited to, the following laws and regulations and all subsequent amendments thereto:

    A. The United States Civil Rights Act of 1964 (as amended), (42 U.S.C. 2000a-2000h)
    B. The United States Civil Rights Act of 1964 (as amended), (Title VI; 42 U.S.C. 2000d et seq.) (See also guidelines to Federal Financial Assistance Recipients regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons)
    C. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. 794)
    D. The Age Discrimination Act of 1975, (42 U.S.C. 6101, et seq.)
    E. The Omnibus Budget Reconciliation Act of 1981
    F. The Americans with Disabilities Act of 1990, (42 U.S.C.12101 et seq.)
    G. Executive Orders 11246 and 11375, (Equal Employment Opportunity) and Executive Order 13166 (2000), (Improving Access to Services for Persons with Limited English Proficiency)
    H. The Missouri Human Rights Act (Mo. Rev. Stat. Chapter 213)

    I and any contractor or subcontractor of mine may not, on the grounds of race, color, national origin, creed, sex, religion, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or any activity connected with the provision of Medicaid services.
6. I understand that I am required to make and maintain records, as required by applicable laws, regulations, rules and policies, included but not limited to fiscal records, medical records, and records related to civil rights issues, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. I understand that I am required to retain these records for five (5) years, and shall make them available on request by an authorized representative of the DSS/MMAC or the U.S. Department of Health and Human Services. I further understand that the retained documents must include all records and documents required by applicable regulations and Medicaid manual and bulletin provisions including the original enrollment documents confirming the provider's original signature. I acknowledge that all services billed through the Medicaid Program are subject to post-payment review, and that this may include unannounced on-site review of records. My failure to submit or failure to retain documentation for all services billed to the Medicaid Program may result in recovery of payments for Medicaid services and may result in sanctions to the provider's Medicaid participation;
7. I understand that either party to this Agreement may terminate my participation in Medicaid under this agreement upon written notice mailed to either my most recent address recorded in the Medicaid enrollment files or the DSS/MMAC. The written notice shall state the reason(s) for the termination. Such reason(s) could include that I am in violation of (a) this agreement, (b) Medicaid claim

certification statement, (c) rules, regulations, policies or procedures of the DSS/MMAC, or (d) State or Local Regulations or Laws which also apply (e.g. fire codes and health codes). All corporations must be registered with the Secretary of State, Corporate Division, and be certified in good standing. I understand that I must be in compliance with all other applicable state or federal laws or regulations. Violation of any law or regulation may result in this agreement being terminated immediately upon mailing of the written notice from the DSS/MMAC; and

8. If at any time state or federally appropriated funds available to the DSS/MMAC for payment to me for covered services under this agreement are insufficient to pay the full amount due, I agree to accept payments reduced in proportion to the funding deficiency.
9. I agree that if I currently provide services or provide services in the future as part of a Rural Health Clinic (RHC), I will deliver and bill Medicaid ONLY for NON-RHC services under my individual or clinic Medicaid provider number. I will maintain a list of on-site services and a contract with the RHC which specifies off-site services that will be provided under my private or clinic practice. A list of costs associated with these services will be maintained and will be provided to the State Medicaid agency upon request. I will not include these services and the associated costs in the RHC cost report. If I am an Independent Provider-Based RHC, I will include a copy of the list of on-site services and contracts in the RHC cost report according to State Regulation 13 CSR 70-94.010, or 13 CSR 70-94.020 if I am a Provider-Based RHC.
10. I understand that even though I do not bill to Medicaid, if I order, prescribe, or refer for Medicaid services this agreement pertains to me as a provider.

I have read and accept the conditions of participation of the Title XIX Participation Agreement for Medicaid Services. I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Missouri Medicaid Program.

I hereby certify that all of the information provided on this application is true and correct, and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the enrolling providers, employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason other than disclosed herein. I authorize the DSS/MMAC to verify the information provided on this application with other state and federal agencies.

ORIGINAL SIGNATURE OF AUTHORIZED SIGNER (STAMP OR OTHER FACSIMILE IS NOT ACCEPTABLE) The authorized signer of this document verifies that he/she is the enrolling individual provider; or for healthcare organizations, a representative of the provider duly authorized as an agent to execute the agreement on behalf of the Provider under authority granted by said Provider.

Typed or Printed name of Provider or Authorized Representative: _____

Original Signature of Provider or Authorized Representative: _____ **Date Signed** _____

Agency Name _____