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| Image result for missouri state seal | MISSOURI DEPARTMENT OF SOCIAL SERVICESMISSOURI MEDICAID AUDIT & COMPLIANCE**MO HEALTHNET PROVIDER ENROLLMENT APPLICATION** |
| **THIS FORM IS MANDATORY FOR ALL PROVIDERS; READ AND ANSWER ALL QUESTIONS CAREFULLY.**Failure to provide this information is grounds for denial of this application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider identifier. EACH form MUST contain an ORIGINAL SIGNATURE. Answer all questions. Attach an additional sheet to provide complete information for any question. Enrollment inquiries may be directed to Provider Enrollment via e-mail at MMAC.ProviderEnrollment@dss.mo.gov. |
| Provider’s Legal Business Name as listed with IRS and SOS  | Doing Business as (DBA) Name – (If applicable) |
| Provider’s Physical Address | Provider’s E-mail Address |
| Contact Person’s Name:  | Business Phone Number | Business Fax Number |
| **All applying providers must submit a separate Ownership & Disclosure attachment to comply with federal and state Medicaid regulations requiring disclosure of all individuals and/or business organizations that have direct or indirect ownership, management and/or control interests. Those federal and state Medicaid regulations are attached to this application.****In addition to submitting the Ownership & Disclosure attachment, providers may utilize separate documents (i.e. organizational chart, spreadsheet, etc.) to identify individuals and businesses with ownership or control interests and all “managing employees” as defined in 13 CSR 65-2.010(21). Those documents must contain the full name (First, middle, last and suffix Jr., Sr., etc.), date of birth, and social security number of each individual who has 5% or greater direct/indirect ownership, controlling interest, partnership interest; any contractor or subcontractor; managing employees; officers or directors; or the legal business name and federal EIN of any organization(s) having direct or indirect ownership or controlling interest. A current copy of the provider’s CMS-855 that includes all this information may be submitted, if one has been completed.** |
| 1. Is this application being made as a result of one or more of the following changes? Yes [ ]  No [ ]

 If yes, check all that apply and complete required section below: Ownership Change [ ]  Merger [ ]  Asset Change [ ]  New clinic formed at same location [ ] Corporate Structure Change [ ]  Replacement Facility [ ]  Other [ ] If other, explain the change(s):  |
| Former owner’s name(s), provider identifier(s), and clinic/facility name(s): |
| New owner’s name and address, clinic/facility names(s): |
| EFFECTIVE DATE OF CHANGE: |
| **A new MO HealthNet provider record is not created for changes; the preceding record is updated. Receiving new identifiers from other agencies/sources does not constitute creating a new MO HealthNet provider record. Payments go to the provider currently indicated on the Provider Enrollment Master File at the time the claim is processed. The provider is responsible for resubmitting any denials or crossover claims for any Medicaid/MO HealthNet services that do not crossover electronically, before and after the change is made to the Provider Enrollment Master File. If a new provider record is created in error due to provider information being withheld at the time of the application, the new record will be made inactive, the preceding record will be updated, and the provider may be subject to sanctions.** |
| 1. For services provided under this application, in which settings will you see patients? Explain if other is chosen.

Office [ ]  Hospital [ ]  Nursing Home [ ]  School [ ]  Patient’s Home [ ]  Other [ ] If other, please explain: |
| **NUMBERS 3 THROUGH 16 – IF YOU ARE COMPLETING THIS APPLICATION AS AN INDIVIDUAL PROVIDER, YOU SHOULD ANSWER THE QUESTIONS FOR YOURSELF. IF YOU ARE AN AUTHORIZED REPRESENTATIVE COMPLETING THIS APPLICATION FOR AN INSTITUTION, YOU SHOULD ANSWER EACH QUESTION ON BEHALF OF ALL INDIVIDUALS WHO HAVE BEEN IDENTIFIED AS HAVING AN OWNERSHIP OR CONTROLLING INTEREST, AND THOSE IDENTIFIED AS MANAGING EMPLOYEES. 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. |
| 1. 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. |
| 1. 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 [ ]
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| 1. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement, the license of the applying provider, any managing employee, or any person having an ownership or control interest; in Missouri or in ANY state? Yes [ ]  No [ ]
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| 1. 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 pertaining to health care in Missouri or ANY other state? Yes [ ]  No [ ]
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| 1. 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: |
| 1. Are there any criminal proceedings 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 practice, clinic, group, corporation or any other association? Yes [ ]  No [ ]

If yes, list pending changes and location: |
| 1. 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: |
| 1. 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 #12 MUST BE COMPLETED.DEA Number: BNDD Number:DEA Number: BNDD Number: |
| 1. 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.
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| 1. 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:
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| 1. 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: |
| 1. 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: |
| 1. Has the applying provider rendered services to a MO HealthNet participant in reference to this application?

Yes [ ]  No [ ]  If yes, complete information below and submit a copy of your license and required documentation covering these dates of service. |
| MO HealthNet participant’s full name: | Participant ID #: | Participant SSN: | Date of Service: |
|  [ ]  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 70-3.020(7), I must advise the Department, in writing, of any changes affecting the provider’s enrollment record.**ORIGINAL Signature of Applicant or Authorized Representative: (Stamp or other facsimile is not acceptable)** |
| **Type or print name and title of person signing this application**: | **Date Signed**: |
| **Submit this enrollment application and all attachments to:****Missouri Medicaid Audit & Compliance, Attn: Provider Enrollment Unit****205 Jefferson Street, 2nd Floor, P.O. Box 6500, Jefferson City, MO 65102****Questions regarding this enrollment packet should be submitted to MMAC.ProviderEnrollment@dss.mo.gov** |

**Federal and State Disclosure Requirements for Medicaid Providers**

**42 CFR § 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.**

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) When the disclosures must be provided—

(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State’s procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(i) Upon the managed care entity submitting the proposal in accordance with the State’s procurement process.

(ii) Upon the managed care entity executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

**42 CFR § 455.105 Disclosure by providers: Information related to business transactions.**

1. Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
2. Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
3. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
4. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
5. Denial of Federal financial participation (FFP)
6. FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
7. FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

**42 CFR § 455.106 Disclosure by providers: Information on persons convicted of crimes.**

1. Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
2. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
3. Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
4. Notification to Inspector General.
5. The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
6. The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider’s application for participation in the program.
7. Denial or termination of provider participation.
8. The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person’s involvement in any program established under Medicare, Medicaid or the title XX Services Program.
9. The Medicaid agency may refuse to enter into or may terminate a provider agreement if

it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

**Missouri Regulation - 13 CSR 65-2.020(3) - Provider Enrollment and Application**

(3) All providers, fiscal agents, and managed care entities are required to disclose as follows:

(A) The following disclosures are mandatory:

1. The name and address of any person with an ownership or control interest in the applying provider. The address for corporate entities must include as applicable primary business address, every business location, and PO Box address;

2. Date of birth and Social Security number (in the case of a corporeal person);

3. Other tax identification number of any person with an ownership or control interest in the applying provider or in any subcontractor in which the applying provider has a five percent (5%) or more interest;

4. Whether any person with an ownership or control interest in the applying provider is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

5. Whether any person with an ownership or control interest in any subcontractor in which the applying provider has a five percent (5%) or more interest is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

6. The name of any other provider or applying provider in which an owner of the applying provider has an ownership or control interest; and

7. The name, address, date of birth, and Social Security number of any managing employee of the applying provider;

(B) Disclosures from any provider or applying provider are due at the following times, and must be updated within thirty-five (35) days of any changes in information required to be disclosed:

1. Upon the provider or applying provider submitting an application; and

2. Upon request of MMAC;

(C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting the proposal;

2. Upon request of MMAC;

3. Ninety (90) days prior to renewal or extension of the contract; and

4. Within thirty-five (35) days after any change in ownership of the fiscal agent;

(D) Disclosures from managed care entities (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting the proposal;

2. Upon request of MMAC; and

3. Ninety (90) days prior to renewal or extension of the contract;

(E) Disclosures from Primary Care Case Management Programs (PCCM). PCCMs will comply with disclosure requirements under subsection (B) of this section;

(F) All Disclosures Must be Provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

(G) Consequences for Failure to Provide Required Disclosures.

1. Any person’s failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination. If the failure is inadvertent or merely technical, MMAC may choose not to impose consequences if, after notice, the person promptly corrects the failure.