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.

Provider Enrollment Application Instructions for Ordering, Prescribing or Referring (OPR) Providers

This application is to be used by individual providers and only if you are enrolling for the sole purpose of ordering, prescribing or referring services/supplies, i.e., prescriptions, durable medical equipment, referrals to specialists, etc. All questions must be completed. Attach additional sheets if necessary to answer each question completely and each additional sheet must display the relevant question number from the application.

If you are already enrolled solely to order, prescribe or refer services/supplies and need to update your information, please complete and submit a Provider Update Form. If you want to terminate your Medicaid enrollment to solely order, prescribe or refer services/supplies, please complete a Provider Update Form.

Requirements:

Enrolling as an OPR provider allows Medicaid reimbursement to providers rendering covered services and supplies for their Medicaid patients. OPR providers do not bill MO HealthNet for the services rendered; they only order, prescribe and/or refer services/supplies for their MO HealthNet patients. A simplified application process requires minimal information and time and makes participation easy. Before completing the application, please note the following:

- If you are already enrolled as a MO HealthNet billing or performing provider, you do not need to enroll as an OPR provider.

- As an OPR provider, you cannot seek reimbursement for services rendered to Medicaid participants and cannot submit claims to MO HealthNet. If at any time you would like to become a fully participating MO HealthNet provider, you must enroll by submitting a new enrollment application form for your specific provider type.
    - You must have a National Provider Identifier (NPI). The NPI is the standard, unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES).
    - The NPI must be for an individual physician or non-physician practitioner (not an organizational NPI).
    - Applying for the NPI is a separate process from MO HealthNet enrollment.
    - To obtain an NPI, apply online at https://nppes.cms.hhs.gov.
    - For more information about NPI enumeration, visit www.cms.gov/NationalProvIdentStand.

- The physician or non-physician practitioner must be of a provider/specialty type that is eligible to order, prescribe and/or refer. These individuals include, but are not limited to:
    - Physicians (Doctors of Medicine or Osteopathy, Doctor of Dental Medicine, Doctors of Dental Surgery, Doctors of Podiatric Medicine or Doctors of Optometry)
    - Optometrists
    - Physician Assistants
    - Clinical Psychologists
    - Clinical Social Workers
    - Nurse Practitioners/Advanced Practice Nurses
    - Certified Nurse Midwives
    - Interns, Residents and Fellows - Must have an NPI to order, prescribe and refer for MO HealthNet participants.

Provider Enrollment Application for Ordering, Prescribing or Referring (OPR) Providers

Section 1: General Information

1. Provider Name: _____
2. NPI Number: _____
3. Provider Date of Birth: _____
4. Social Security Number: _____
5. Requested Effective Date: _____
6. Physical Address: _____
7. Mailing Address: _____
8. Provider Email Address: _____
9. Telephone Number: _____
10. Fax Number: _____
11. DEA Number (if applicable): _____

Section 2: License/Certification Information

- List all professional licenses or certifications for all states.
- Add additional copies of this page if more space is needed.

License Number	Issuing State	Effective Date	End Date

Section 3 – Medical Specialties

- Indicate your specialty

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

__ Addiction Medicine
__ Allergy/Immunology
__ Anesthesiology
__ Cardiac electrophysiology
__ Cardiac surgery
__ Cardiovascular disease (Cardiology)
__ Colorectal surgery (Proctology)
__ Critical Care (Intensivists)
__ Dermatology
__ Diagnostic Radiology
__ Emergency Medicine
__ Endocrinology
__ Family practice
__ Gastroenterology
__ General practice
__ General surgery
__ Geriatric medicine
__ Geriatric psychiatry
__ Gynecological oncology
__ Hand surgery
__ Hematology
__ Hematology/Oncology
__ Hospice
__ Infectious disease
__ Internal medicine
__ Interventional pain management
__ Interventional radiology
__ Medical oncology
__ Nephrology
__ Neurology
__ Neuropsychiatry
__ Neurosurgery
__ Nuclear Medicine
__ Obstetrics/Gynecology
__ Ophthalmology
__ Optometry
__ Oral Surgery (Dentist Only)
__ Orthopedic surgery
__ Osteopathic manipulative medicine
__ Otolaryngology
__ Pain Management
__ Palliative care peripheral vascular disease
__ Physical medicine and rehabilitation
__ Plastic and reconstructive surgery
__ Podiatry
__ Preventative medicine
__ Psychiatry
__ Pulmonary disease
__ Radiation oncology
__ Rheumatology
__ Sports Medicine
__ Surgical oncology
__ Thoracic surgery
__ Urology
__ Vascular surgery
__ Unlisted physician type
Specify: _____

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.

__ Certified Nurse Midwife
__ Certified Registered Nurse Anesthetist
__ Nurse Practitioner
__ Clinical Psychologist
__ Clinical Social Worker
__ Dentist
__ Physician Assistant
__ Unlisted non-physician practitioner type
Specify: _____

Section 4 – Final Adverse Legal Actions/Convictions

Please provide information on final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse actions must be reported, regardless of whether any appeals are pending.

Convictions

1. The physician or non-physician practitioner was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a federal or state felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation, suspension, probation, or reprimand of a license to provide health care by any state licensing authority. This includes the surrender of such license while a formal disciplinary proceeding was pending before a state licensing authority.
2. Any revocation, suspension, probation or reprimand of an accreditation.
3. Any termination, suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal Executive Branch procurement or non-procurement program.
4. Any past or present Medicare/Medicaid payment suspension under any Medicare/Medicaid identification number.
5. Any Medicare/Medicaid revocation of any Medicare/Medicaid identification number.

Have you, under any past or present name or business entity, ever had a final adverse legal action, listed above, imposed against you?

_____ Yes _____ No

If no, skip to the Provider Signature in Section 5.

If yes, complete the fields listed below to report each final adverse legal action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and the resolution. If you need more room, attach a separate sheet.

If yes, attach a copy of the final adverse legal action documentation.

Briefly describe adverse legal action:	Date:	Taken By:	Resolution:

Section 5 – Provider Signature/Attestation

By execution of this attestation, the undersigned individual "Provider" agrees to participate as a provider in the MO HealthNet program for the sole purpose of ordering, prescribing, or referring (OPR) services to MO HealthNet participants. To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Department of Social Services (DSS) and the Missouri Medicaid Audit & Compliance Unit (MMAC). 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 records.

Legal Name of Provider: _____

Provider Signature: _____

Date Signed: _____

- **Fax the enrollment application and required attachments in one transmission to: 573-634-3105.**
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- **Only one application and it's attachments are accepted per transmission.**
- **Questions regarding this enrollment should be submitted to: MMAC.ProviderEnrollment@dss.mo.gov.**

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.

Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Email Address (if applicable) _____

Relationship or Affiliation to You: _____

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. MMAC will not discuss any other Medicaid issues about you with the above Contact Person.

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 _____