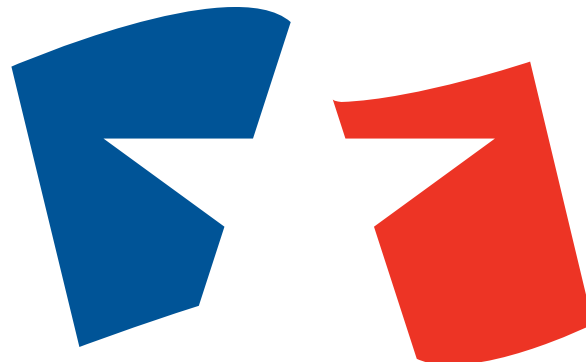


CHILDREN WITH SPECIAL
HEALTH CARE NEEDS
(CSHCN) SERVICES PROGRAM
PROVIDER ENROLLMENT
APPLICATION



TMHP
TEXAS MEDICAID
&
HEALTHCARE PARTNERSHIP

A STATE MEDICAID CONTRACTOR

REV. XIII



Application for Children with Special Health Care Needs (CSHCN) Services Program Provider Enrollment

EXPLANATION OF PREREQUISITES

- Applicant must be currently enrolled in the Texas Medicaid Program.
- Applicants must provide current Texas Medicaid Provider numbers. (To verify status of compliance, call the TMHP Contact Center at 1-800-925-9126).

EXPLANATION OF REQUIRED ATTACHMENTS FOR ENROLLMENT

- W-9 form must be submitted with your completed Program Enrollment Application if it has been more than six months since your last W-9 submission.
- For enrollment in the CSHCN Services Program, please complete this form and the Department of State Health Services (DSHS) Participation in the Children with Special Health Care Needs (CSHCN) Services Program Provider Agreement. For assistance with completing this form, please call the provider helpline at 1-800-568-2413.

Note: *Additional documents are required for specialty center/team enrollment. Contact TMHP at 1-800-568-2413 for details.*

DISCLAIMER

- Providers should understand that by signing the Program Enrollment Application the provider is agreeing to an extension of the terms included in the Provider Agreement for the provider number listed in this application.
- The signature provided on the Program Enrollment Application must be the signature of the person who is seeking enrollment into the CSHCN Services Program:
 - The provider's signature is required on the attached document for any/all enrollment requests for individual practitioner provider numbers.
 - Signatures by the *authorized representative* of a *group or facility* only are acceptable for enrollment requests for group/facility provider numbers.





CSHCN Services Program Identification Form

All provider types must be enrolled with the Texas Medicaid Program as a prerequisite to enrolling in the CSHCN Services Program. Call the TMHP Contact Center at 1-800-925-9126 for information about the Texas Medicaid Program and provider enrollment criteria.

To ensure proper enrollment, check the appropriate boxes below to indicate all services you will provide.

✚ Must Designate If Public Provider

DEFINITION: *Public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations (CFR), including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.*

| | |
|---|--|
| Are you a private entity? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a public entity? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Advanced Nurse Practitioner <input type="checkbox"/> ✚ Ambulance / Air Ambulance Services <input type="checkbox"/> ✚ Ambulatory Surgical Center <input type="checkbox"/> Augmentative Communicative Devices <input type="checkbox"/> Dental Services <input type="checkbox"/> Orthodontia Services <input type="checkbox"/> Respiratory Care Practitioner <input type="checkbox"/> Custom Durable Medical Equipment (DME) Services (Custom DME is medical equipment made or modified specifically to address the individual client's needs.) <input type="checkbox"/> Non-custom DME Services (Non-Custom DME is medical equipment that can be obtained from a store or mail-order company and does not require adaptation or modification for the client's use.) <input type="checkbox"/> Hemophilia Blood Factor Products <input type="checkbox"/> Expendable Medical Supplies <input type="checkbox"/> Medical Nutritional Services (Licensed Dietitians) <input type="checkbox"/> Medical Nutritional Products <input type="checkbox"/> Total Parenteral Nutrition (TPN) Services <input type="checkbox"/> Stem Cell Transplant Facility <input type="checkbox"/> Hospice <input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA) <input type="checkbox"/> Optometrist (OD) <input type="checkbox"/> Licensed Clinical Social Worker (LCSW) <input type="checkbox"/> Comprehensive Cleft/Craniofacial Team | <input type="checkbox"/> Provider Affiliated with a Comprehensive Cleft/Craniofacial Team <input type="checkbox"/> Independent Diagnostic Testing Facility (IDTF) <input type="checkbox"/> Orthotic Services <input type="checkbox"/> Prosthetic Services <input type="checkbox"/> Free-Standing Surgical Centers <input type="checkbox"/> Skilled Nursing Services (Home Health Agency) <input type="checkbox"/> Hospital Services (including Inpatient Rehabilitation Services) <input type="checkbox"/> Independent Laboratory Services <input type="checkbox"/> Occupational Therapy Services <input type="checkbox"/> Physical Therapy Services <input type="checkbox"/> Physician Services <input type="checkbox"/> Renal Dialysis Facility <input type="checkbox"/> Speech-Language Pathology Services <input type="checkbox"/> Transportation of Remains (Medicaid enrollment is not required for this provider type) <input type="checkbox"/> Licensed Professional Counselor (LPC) <input type="checkbox"/> Psychologist <input type="checkbox"/> Medical Foods <input type="checkbox"/> Optician <input type="checkbox"/> Vision Medical Supplier |





Applicant enrolling as: Individual Group Facility Performing Provider

- All information must be completed or marked "N/A" and contain a valid signature to be processed.
- Original signatures are required. Copies or stamped signatures will not be accepted.
- Please use blue or black ink.
- CSHCN Services Program providers must inform DSHS, or its designee, in writing, of any changes or if additional information becomes available. Please contact TMHP Provider Enrollment at 1-800-568-2413 if you have any questions.

SECTION A — Provider of Service Information

| | | | |
|---|--|--|--|
| Existing Medicaid Texas Provider Identifiers (TPIs) | | | |
| <i>Please list all other assigned Texas Medicaid TPIs in the boxes to the right</i> | | | |
| Please list the National Provider Identifier (NPI) and Taxonomy Codes (if available) | | | |
| | | | |

| Group/Company or Last Name | First | Initial | Title/Degree |
|----------------------------|-------|---------|--------------|
| | | | |

| Provider business e-mail | Business web site address |
|--------------------------|---------------------------|
| | |

| Telephone Number | Social Security Number (For Individual Enrollment Only) | Professional License Number | Professional License Issue Date MM/DD/YY | Professional License Expiration Date MM/DD/YY |
|------------------|--|-----------------------------|---|--|
| | | | | |

| Date of Birth MM/DD/YY | Employer's Tax ID No. | Legal Name According to the IRS (Identical to W-9) |
|---------------------------|-----------------------|---|
| | | |

| Primary Specialty | Sub-Specialty |
|-------------------|---------------|
| | |

| Physical Address — <i>Where services are rendered.</i> | | | | | |
|--|--------|-------|------|-------|-----|
| Number | Street | Suite | City | State | ZIP |
| | | | | | |

| Accepting New Clients? (yes or no) | Counties Served | Client Age Restrictions | Gender Limitations |
|------------------------------------|-----------------|-------------------------|--------------------|
| | | | |

| Accounting/Billing Address — <i>Where provider information to be sent.</i> | | | | | |
|--|--------|-------|------|-------|-----|
| Number | Street | Suite | City | State | ZIP |
| | | | | | |





SECTION B — Owners, Partners, Officers, Directors, and Principals

Identify sole proprietor or all owners, partners, officers, directors, and principals (as defined in Principal Information Form [PIF-2]) of the applicant, including title, social security number, date of birth, driver’s license number and state, and list the percentage of ownership, if applicable. Total ownership should equal 100 percent.

| Name | Title | Social Security Number | Date of Birth MM/DD/YY | Drivers License Number | Percentage Owned |
|------|-------|------------------------|---------------------------|------------------------|------------------|
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SECTION C—GROUP PRACTICE *Required if enrolling as a GROUP PRACTICE*

Indicate the type of group enrollment you are requesting by checking one of the following:

- Adding performing provider(s) to an existing group (*Indicate Group TPI below*)
- Enrolling a new group with performing provider(s)

If enrolling a new group, list all individuals who will be performing providers of the group below. If adding individuals to an existing group, list the existing CSHCN Services Program group billing number and indicate individuals to be added below..

Existing CSHCN Services Program Group Number:

| Name | Date of Birth | License Number | License Issue Date MM/DD/YY | Social Security Number | Medicaid Provider Number | Title/Degree |
|------|---------------|----------------|--------------------------------|------------------------|--------------------------|--------------|
| | | | | | | |
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I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform DSHS or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

(Signature of applicant or an authorized representative if you are enrolling as a provider group/supplier)

Signature **Date**
(Must be signed by the individual applicant, or if entity, must be signed by an owner, officer, director, principal, or partner of applicant.)

Typed Name **Date**





Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program

| |
|--|
| Legal Name of Provider / Facility |
| |

| | | | |
|----------------|-------------|--------------|-----------------|
| Address | City | State | Zip Code |
| | | | |

| | |
|---------------------|--|
| Medicaid TPI | CSHCN Services Program TPI — (assigned by designee) |
| | |

The provider agrees, in accordance with the state laws, rules and regulations pertaining to DSHS, CSHCN Services Program, and as a condition for participation in this program, to the terms and conditions set forth below:

1. A copy of the current *CSHCN Services Program Provider Manual* has been or will be furnished to the Provider. The provider manual, all revisions made to the provider manual through quarterly CSHCN Services Program provider bulletins, and written notices are incorporated into this Agreement by reference. **The CSHCN Services Program Provider Manual, bulletins, and notices may be accessed via the internet at www.tmhp.com. Providers may obtain a copy of the manual by calling 1-800-568-2413.** Provider has a duty to become familiar with the contents and procedures contained in the provider manual. Provider agrees to comply with all the requirements of the provider manual, as well as all state and federal laws and amendments, governing or regulating CSHCN Services Program. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the provider manual and all state and federal laws and amendments governing or regulating CSHCN Services Program.
2. To maintain and retain for a period of five years from the date of service, or until audit and all audit exceptions are resolved, whichever period is longer, such records as are necessary to fully disclose the extent of the services provided to the clients receiving assistance under the CSHCN Services Program and any information relating to payments claimed by the Provider. Providers must cooperate and assist DSHS or its designee, the Texas Health and Human Services Commission (HHSC), Office of Inspector General, and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their designees access to its premises as required by Title 1 *Texas Administrative Code* (TAC) §1643. If litigation is involved, the records must be retained until litigation is ended or for five (5) years as cited above, whichever is longer.
3. To provide unconditionally, upon request, free copies of and access to all records pertaining to the services for which claims are submitted to CSHCN Services Program or its designees.
4. To accept CSHCN Services Program payment as payment in full for service. Provider may collect allowable insurance or health maintenance organization copayments in accordance with those plan provisions.





5. Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes and provide such information, on request, to HHSC, DSHS, Office of the Inspector General, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the CSHCN Services Program current by informing DSHS or its designee in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify DSHS or its designee within 10 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must submit to DSHS complete information related to any such suspension or restriction.

Provider agrees to disclose all convictions of Provider and Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in Title 42, *Code of Federal Regulations* (CFR) §1001.2. All principals of the Provider include an owner with a direct or indirect ownership or control interest of 5% or more, is an agent or managing employee of the Provider, is a corporate officer or director, general or limited partner, agent, managing employee (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof.

6. The Office of Inspector General, internal and external auditors for the state/federal government, DSHS and/or HHSC may conduct interviews of the Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, subcontractors and their employees, witnesses, and clients must not be coerced by the Provider or Provider's representative, to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control, cooperate fully in any investigation conducted by the Office of Inspector General. Subcontractors are those persons or entities that provide medical goods or services for which the Provider bills the CSHCN Services Program or who provide billing, administrative, or management services in connection with CSHCN Services Program covered services.
7. Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by DSHS and HHSC, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims will be true, accurate, and complete, and that the Provider's records and documents are accessible and validates the services and the need for services billed and represented as provided. Further, Providers understand that any falsification or concealment of a material fact may be prosecuted under state and federal laws.
8. To accept payments established by the Texas Medicaid Program as payment in full for Medicaid covered services for those clients who are assisted by this resource.
9. To utilize CSHCN Services Program as a resource for payment when clients are eligible for program assistance.
10. Provider acknowledges that it/they have executed an HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts. All of the provisions of the HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts are hereby incorporated by reference in this Provider Agreement with the Department of State Health Services (DSHS) for participation in the Children with Special Health Care Needs (CSHCN) Services Program.





11. To utilize Texas Medicaid, Children's Health Insurance Program (CHIP), and/or private insurance (including HMO coverage) and the United States Department of Defense or Department of Veterans Affairs benefit plans as sources for reimbursement because they are primary to CSHCN Services Program payments.
12. To not bill the client/family for the cost of any charges not paid for by CSHCN Services Program due to the provider's failure to request the required authorization and/or failure to submit a claim for reimbursement within the appropriate submission deadline.
13. To not charge the client/family any pre-admission or pretreatment charges or deposits if services are reimbursable by CSHCN Services Program.
14. To refund the client/family any pre-admission or pretreatment charges when services are authorized and collection occurred prior to program application and eligibility determination.
15. To request authorization from CSHCN Services Program, before the date of service, for all services requiring prior authorization.
16. To request authorization from CSHCN Services Program for all services requiring authorization before the date of service or up to 95 days after the date of service.
17. That claims submitted by me, or on my behalf, for payment by the CSHCN Services Program shall be for services or items actually provided by me or under my personal supervision to the eligible recipient identified as the client for which I am entitled to payment. Claims must be submitted in the manner and in the form set forth in the *CSHCN Services Program Provider Manual* and within the time limits established by DSHS for submission of claims. The provider understands that payment and satisfaction of such claims will be from federal and/or state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and /or state laws. Fraud is a felony, which can result in fines and imprisonment.
18. Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Provider's failure to provide timely notice.

Provider must have a written contract with any person or entity for the purpose of billing Provider's claims, unless the person or entity is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on the person. The contract must be signed and dated by the Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according to the CSHCN Services Program records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the CSHCN Services Program.
- Biller understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients. Provider understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings directly or indirectly, to the Biller or to the CSHCN Services Program or its contractor.





- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the CSHCN Services Program.
 - Biller agrees to enroll and be approved by the CSHCN Services Program as a Third Party Billing Vendor prior to submitting claims to the CSHCN Services Program on behalf of the Provider.
 - Biller and Provider agree to notify the CSHCN Services Program within 5 working days of the initiation and termination, by either party, of the contract between the Biller and the Provider.
19. To be payable by CSHCN Services Program, services must be personally performed by a physician or by a qualified person working under the personal or direct supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided. In instances where one physician is taking calls for another physician, the performing physician must bill the services provided.
 20. Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct, are received by DSHS or its designee within CSHCN Services Program deadlines, and to implement an effective method to track submitted claims against payments made by DSHS or its designee.
 21. Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund to CSHCN Services Program any overpayments, duplicate payments, and or erroneous payments to which entitlement is not authorized under CSHCN Services Program rules and regulations that are paid to Provider by CSHCN Services Program or its designee as soon as the payment error is discovered.
 22. To comply with Title VI of the Civil Rights Act of 1964 (Public Law 88–352), Sections 504 of the Rehabilitation Act of 1973 (Public Law 93–112), The Americans with Disabilities Act of 1990 (Public Law 101–336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the provider agrees to comply with Title 40, Chapter 73, of the TAC. These provide, in part, that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination. To comply with Texas Health and Safety Code, Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).
 23. Provider agrees to not discriminate against the individual on the basis the person is a CSHCN Services Program recipient by means of pricing differentials or other means of discriminatory treatment. Provider must not exclude or deny aid, care, service, or other benefits available under CSHCN Services Program or in any other way discriminate against a person because of that person’s race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to CSHCN Services Program clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to apply to CSHCN Services Program recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the CSHCN Services Program for CSHCN Services Program recipients and discounted services to the general public must not be billed to CSHCN Services Program for a CSHCN Services Program recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.
 24. To provide language assistance that may be required for effective communication with CSHCN Services Program recipients who demonstrate limited English proficiency to insure they have equal access to services.
 25. To accept responsibility for informing and ensuring that those acting as my agents understand and follow CSHCN Services Program rules and regulations.





- 26. To comply with all requirements of CSHCN Services Program regulations, rules, standards, and guidelines published by CSHCN Services Program or its designee.
- 27. To maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.
- 28. To promptly report change of address and/or change in status, including but not limited to change in name, loss of license, change in certification status, or change in Medicaid provider status.
- 29. To maintain provider enrollment and participation in the Texas Medicaid Program as a condition to participate in CSHCN. Should Texas Medicaid status be terminated, participation in CSHCN Services Program may be terminated effective the date of Medicaid termination.
- 30. That this agreement may be terminated by either party upon thirty (30) days notice to the other party, except that termination may be earlier for submitting false or fraudulent claims, failing to provide and maintain quality services or medically acceptable standards, failure to comply with the provider agreement signed at the time of application or renewal for CSHCN Services Program participation, disenrollment as a Medicaid provider or violation of the standards of CSHCN Services Program rules and regulations or parts thereof. Provider specifically agrees that Paragraphs 2, 3, and 27 of this Agreement concerning client record retention, access by DSHS to records pertaining to CSHCN Services Program services, and confidentiality of client records and information shall remain in effect and binding upon provider if the remainder of this Agreement is terminated for any reason.
- 31. DSHS and the CSHCN Services Program expect providers to comply with the provisions of State law as set forth in Chapter 261, *Texas Family Code*, related to the reporting of child abuse and neglect.

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform DSHS or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Name of Provider / Facility

Signature

Date

(Must be signed by the individual applicant, or if entity, must be signed by an owner, officer, director, principal, or partner of applicant)

Typed Name

Position / Title

It is recommended that you retain a copy of this document for your records.

