

Provider Information Form (PIF-1)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a provider agreement or contract in force with a Medicaid operating agency, and who has a provider number issued by the Commission or their designee to:

- (1) provide medical assistance, Medicaid, under contract or provider agreement with the Commission or its designee; or
- (2) provide third party billing services under a contract or provider agreement with the Commission or its designee

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Last, First, Middle Name OR Group/Company Name	Maiden Name
List any other Alias, Name or Form of your name ever used	National Provider Identifier (NPI) (10 digit)
Primary Taxonomy Code (10 digit)	
Secondary Taxonomy Code (10 digit) <i>The provider may indicate up to 15 taxonomy codes; please attach additional pages if needed.</i>	
Non Texas Enrolled Taxonomy Codes	

For additional names or addresses, please attach necessary pages.

Physical Address					
Number	Street	Suite	City	State	ZIP

Accounting/Billing Address					
Number	Street	Suite	City	State	ZIP

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

- Third Party Biller
 Management Company
 Employer
 Self
 Other (*explain below*)

Explain if "Other" was selected.



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Professional Licensing board, Professional License Number, and State		Professional License Initial Issue Date MM/DD/YY	Professional License Current Expiration Date MM/DD/YY	
Social Security Number		Employer's Tax ID		
Specialty of Practice (Example: Pediatrics, General Practice, etc.)		Medicare Intermediary		
Medicare Provider Number		Medicare Effective Date MM/DD/YY		
Driver's License Number	State Issuer	Driver's License Expiration Date MM/DD/YY		
Date of Birth MM/DD/YY		Gender		
		<input type="checkbox"/> M <input type="checkbox"/> F		
CLIA Number (attach a copy of the CLIA certification)				
CLIA Address (list the address listed on the CLIA Certificate)				
Number	Street	Suite	City	State ZIP
Previous Physical Address				
Number	Street	Suite	City	State ZIP

Previous Accounting/Billing Address				
Number	Street	Suite	City	State ZIP

Do you plan to use a Third Party Biller to submit your Medicaid claims?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide the following information about the billing agent:</i>	
Billing Agent Name	Address
Tax ID Number	
Contact Person Name	Telephone Number

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/Atypical Provider Identifier (API) or TPI of each Provider or entity (attach additional sheets if necessary):

“Sanction” is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

Have you ever been sanctioned (as defined above) in any state or federal program?

Yes No *If yes, fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected (attach additional sheets if necessary):*

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Is your professional license or certification currently revoked, suspended or otherwise restricted? Yes No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted? Yes No
Are you currently or have you ever been subject to a licensing or certification board order? Yes No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? Yes No

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. (You may be subject to a criminal history check.)

Convicted means that:

(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

- (1) There is a post-trial motion or an appeal pending, or
- (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Yes No *If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of (attach additional sheets if necessary):*

Are you currently behind 30 days or more on court ordered child support payments?

Yes No *If yes, provide details (attach additional sheets if necessary):*

Are you a citizen of the United States?

Yes No

If no, of what Country are you a citizen?

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.

