



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
TMHP A STATE MEDICAID CONTRACTOR

# Texas Medicaid Enrollment Application

**Individuals**

V. II

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**Note:** For help with completing any of the forms above, please refer to the Individual Application Instructions document, which is available for download from the forms page of the TMHP website at [www.tmhp.com](http://www.tmhp.com).

# Contact Information

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## Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address identified on this application as the location where Medicaid services are being provided.

|                                       |  |               |                                     |             |              |                 |
|---------------------------------------|--|---------------|-------------------------------------|-------------|--------------|-----------------|
| <b>Contact Name:</b> <i>Last</i>      |  | <i>First</i>  | <i>Middle Initial</i>               |             |              |                 |
|                                       |  |               |                                     |             |              |                 |
| <b>Contact Telephone Number:</b>      |  |               | <b>Contact Fax (if applicable):</b> |             |              |                 |
|                                       |  |               |                                     |             |              |                 |
| <b>Email Address (if applicable):</b> |  |               |                                     |             |              |                 |
|                                       |  |               |                                     |             |              |                 |
| <b>Address:</b> <i>Number</i>         |  | <i>Street</i> | <i>Suite No.</i>                    | <i>City</i> | <i>State</i> | <i>ZIP Code</i> |
|                                       |  |               |                                     |             |              |                 |

# Medicare Enrollment Information

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**REQUIRED:** Medicare enrollment is a prerequisite for Medicaid enrollment if you render services for clients who are eligible for Medicare.

Are you using a Medicare certification number for this enrollment?  Yes  No

**Important:** Do not continue with this application if your Medicare certification is pending. Once you have received a Medicare certification number, you may submit an application (an online application is recommended) for enrollment into Texas State Health-Care Programs. Your enrollment effective date will be retroactive to your Medicare certification date. Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service.

## Medicare Waiver Request

If you are eligible to request a Medicare waiver, choose one of the following and continue with this application.

**Note:** A signed explanation / justification letter on company letterhead must be submitted to TMHP with submission of this application's signature page for consideration of the Medicare Waiver Request.

- I certify my practice is limited to individuals birth through 20 years of age. I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled.
- I certify that the service(s) I render is / are not recognized by Medicare for reimbursement. I further certify the claims for these services will not be billed to Medicare (this includes Medicare crossover claims). I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled.

## Medicare Billing Acknowledgement Statement

You *must* check the box below if you are a provider who is not using a Medicare certification number for this enrollment.

- I understand that the services that are provided to Medicare-eligible clients cannot be billed to Medicaid unless Medicare is billed first. If the services are not billed to Medicare first, Medicaid may recoup payments for the services. I also understand that I cannot bill the client for these services.

# Application Payment Form

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In accordance with ACA and 42 CFR 455.460, certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications for a new practice location
- Applications received in response to re-enrollment

An application fee is not required and will not be accepted if the provider is enrolled in Medicare, another State's Medicaid program, or another Texas State agency. Providers will be required to submit details and/or payment of other programs or agencies to TMHP with submission of this application.

## **I am Not Using a Medicare Number for This Enrollment**

**Instructions:** *If you are not using a Medicare certification number for this enrollment, select ONE of the following:*

I am submitting the application fee to Texas Medicaid by paper check, money order, or cashier's check with this application.

**Note:** *Providers must include a check, money order, or cashier's check with their Texas Medicaid provider enrollment packet submission for the application fee. Cash cannot be accepted. Make the check payable in the amount of \$586.00 to Texas Medicaid & Healthcare Partnership (TMHP). Include the Portal Ticket Number on the check and print the PEP Cover letter. Mail the printed PEP Cover letter with the check.*

I attest that I have already paid the application fee to another state's Medicaid program or CHIP program and have been approved for enrollment in another state's Medicaid program or CHIP program. My proof of payment and enrollment is attached to this application. I understand that if my proof of payment to another state's Medicaid program or CHIP program is found to be unacceptable for any reason, I may be required to pay an application fee towards my Texas Medicaid enrollment application.

I am requesting an application fee waiver due to financial hardship. My documentation that supports my request is attached to this application. I understand that I must submit a letter (and supporting documentation) with my enrollment application that details the reason(s) I am unable to pay an application fee. I understand that if the waiver request is denied, I will be required to submit an application fee if I wish to proceed with the Texas Medicaid enrollment process.

**Note:** *If hardship waiver was issued by another state, you must also request a waiver from Texas Medicaid.*

The application fee is not applicable for my provider type.

# Texas Medicaid Identification Form

|                                       |   |   |
|---------------------------------------|---|---|
| <b>Type of Enrollment:</b>            | <input type="checkbox"/> New enrollment (new provider, practice location, etc.) | <input type="checkbox"/> Re-enrollment      |
| <b>Requesting Enrollment As:</b>      | Individual  | <b>NPI:</b>                                 |
| <b>Additional Program Enrollment:</b> | <input type="checkbox"/> CSHCN Services Program                                 | <input type="checkbox"/> Texas Health Steps |

**Note:** If you are also enrolling in the CSHCN Services Program, you must complete the following forms that are available for download at [www.tmhp.com](http://www.tmhp.com):

- CSHCN Services Program Identification Form
- Provider Agreement with the Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program
- Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider (as applicable)

## Provider Type Selection

Please check only the appropriate box to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to the instructions.

### TRADITIONAL SERVICES:

- Audiologist ★ ✪ ▲
- Certified Nurse Midwife (CNM) ★ ▲ ▼
- Certified Registered Nurse Anesthetist (CRNA) ★ ▲
- Chiropractor ★ ▲
- Dentist/Doctor of Dentistry as a Limited Physician ★ ✪ ▲
- Family Planning Agency ✚ ▼
- Genetics ✚ ▲
- Hearing Aid ▲ ✪
- Licensed Marriage and Family Therapist (LMFT) ▲
- Licensed Professional Counselor (LPC) ▲
- Licensed Midwives ▲ ▼
- Nurse Practitioner/Clinical Nurse Specialist (NP/CNS) ★ ✪ ▲ ▼

- Occupational Therapist (OT) ★ ▲
- Optician ★
- Optometrist (OD) ★ ✪ ▲
- Orthotist ★ ✪ ▲
- Pharmacist ★ ▲
- Physical Therapist (PT) ★ ▲
- Physician (MD, DO) ★ ✪ ▲ ▼  
*OB/GYN and Pediatricians not required to have a Medicare Number*
- Physician Assistant ★ ✪ ▲ ▼
- Podiatrist ★ ▲
- Prosthetist ★ ✪ ▲
- Prosthetist - Orthotist (choose if licensed as both) ★ ✪ ▲
- Psychologist ★ ▲
- Respiratory Care Practitioner (CRCP) ▲
- Social Worker (LCSW) ★ ✪ ▲
- Speech-Language Pathologist (SLP) ★ ▲

### CASE MANAGEMENT SERVICES:

- Case Management for Children and Pregnant Women ▲ ●

### COMPREHENSIVE CARE PROGRAM (CCP) SERVICES:

- Dietician ▲
- Licensed Vocational Nurse (LVN) ▲
- Occupational Therapist (OT-CCP) ▲
- Physical Therapist (PT-CCP) ▲
- Registered Nurse (RN) ▲
- Speech-Language Pathologist (SLP-CCP) ▲

## Texas Vaccines for Children Program (TVFC)

Texas Medicaid does not reimburse for vaccines available from Texas Vaccines for Children (TVFC) program.

- Yes  No Do you currently receive free vaccines from TVFC? (if No, answer the next question)
- Yes  No Does your clinic/practice provide routinely recommended vaccines to children birth through 18 years of age? (If Yes, complete the Texas Vaccines for Children Program Provider Agreement available at [www.dshs.texas.gov/immunize/tvfc/ProviderResources.shtm](http://www.dshs.texas.gov/immunize/tvfc/ProviderResources.shtm).)

### Legend:

- Approval Letter/Contract required
- ▲ License/certification required
- ◆ Palmetto number required
- ✪ Eligible for Medicare waiver request (you must check a Medicare waiver request box on page 4)
- ✪ Proof of fingerprinting required
- ▼ Healthy Texas Women (HTW) Certification required for reimbursement
- ★ Medicare number required
- ✚ Must designate if public provider

# Provider of Services Information

All of the following information must be completed by all applicants and contain a valid signature to be processed. If a question or answer does not apply, enter "N/A". Use *only* blue or black ink.

## Provider Type Specific Information

|   |   |
|---|---|
| <b>Public/Private Entities</b> <i>(required for all providers):</i><br><b>Definition:</b> Public entities 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, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds. |   |
| <b>Are you a private or public entity?</b>  | <input type="checkbox"/> Private <input type="checkbox"/> Public  |
| <b>THSteps and Family Planning Providers Only:</b>  | <b>Are you licensed as a Physician Assistant (PA) or a nurse recognized as an Advanced Practice Registered Nurse (APRN)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>If "Yes," please list the appropriate Sub-Specialty in the Provider Specialty/Taxonomy Information section below (Certified Nurse Midwife [CNM], Clinical Nurse Specialist [CNS], Nurse Practitioner [NP], or PA). |

## Provider Specialty/Taxonomy Information

|  |   |  |                             |
|--|---|--|-----------------------------|
| <b>Specialty:</b>                                  |   | <b>Sub-Specialty</b> <i>(if applicable):</i> |                             |
| <b>Primary Taxonomy Code</b> <i>(10-digit):</i>    |   |  |                             |
| <b>Secondary Taxonomy Code*</b> <i>(10-digit):</i> |   |  |                             |
| <b>Audiologist and Hearing Aid Providers Only:</b> | <b>Do you provide hearing services for children?</b>    | <input type="checkbox"/> Yes                 | <input type="checkbox"/> No |
|  | <b>Will you be fitting and dispensing hearing aids?</b> | <input type="checkbox"/> Yes                 | <input type="checkbox"/> No |

\* Providers may list up to 15 taxonomy codes; attach additional pages if necessary.

## Provider Demographic Information

|   |  |                                |             |
|---|--|--------------------------------|-------------|
| <b>Existing TPIs</b> <i>(if applicable):</i>  |  |                                |             |
| <b>Do you want to be a limited provider?</b> <i>(see instructions for definition of "limited provider")</i>             | <input type="checkbox"/> Yes               | <input type="checkbox"/> No    |             |
| <b>Last Name, First Name:</b>   | <b>Maiden Name</b> <i>(if applicable):</i> |                                |             |
|   |  |                                |             |
| <b>List any other alias, name, or form of your name ever used:</b>  |  |                                |             |
| <b>Title/Degree:</b>  |  | <b>Social Security Number:</b> | <b>DOB:</b> |
| <b>Federal/Employer Tax ID Number:</b>  |  |                                |             |
| <b>Legal Name According to the IRS</b> <i>(must match the legal name field on the W-9 and Disclosure of Ownership):</i> |  |                                |             |
|   |  |                                |             |
| <b>Communication Preference:</b>  | <input type="checkbox"/> Email             | <input type="checkbox"/> Mail  |             |
| <b>Provider Business Email</b> <i>(required):</i>   |  |                                |             |
| <b>Secondary Email Address</b> <i>(optional):</i>   |  |                                |             |
| <b>Provider Website Address</b> <i>(if applicable):</i>   |  |                                |             |

*(continued on next page)*

(continued from previous page)

|  |  |  |  |
|--|--|--|--|
| <b>Physical Address Where Health Care is Rendered*</b> (Number, Street, Suite No., City, State, ZIP):  |  |  |  |
|  |  |  |  |
| <b>Accounting Address</b> (Number, Street, Suite No., City, State, ZIP):   |  |  |  |
|  |  |  |  |
| <b>If your accounting address is different than your physical address, indicate your relationship to the accounting address:</b>   |  |  |  |
| <input type="checkbox"/> Third Party Biller <input type="checkbox"/> Management Company <input type="checkbox"/> Employer <input type="checkbox"/> Self <input type="checkbox"/> Other (explain below) |  |  |  |
| <b>If "Other," please explain:</b>   |  |  |  |
| <b>Telephone No.:</b>  |  | <b>Physical Address FAX No.:</b>   |  |
| <b>Accounting/Billing Address FAX No. (optional):</b>  |  |  |  |
| <b>Accepting New Clients:</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No                                       | <b>Gender Served:</b>  | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> All |
| <b>Client Age Restrictions:</b>  |  |  |  |
| <b>Counties Served:</b>  |  |  |  |
| <b>Indicate your reason for applying to join the Texas State Health-Care Programs (Select one):</b>  |  |  |  |
| <input type="checkbox"/> Access to an online application   | <input type="checkbox"/> Learned about Texas State Health-Care Programs at a provider workshop | <input type="checkbox"/> Recruited by Texas State Health-Care Programs staff           | <input type="checkbox"/> Recruited by TMHP Provider Relations representative               |
| <input type="checkbox"/> Adding a new location   | <input type="checkbox"/> Improved administrative processes                                     | <input type="checkbox"/> Re-enrolling a provider under an existing provider identifier | <input type="checkbox"/> Reimbursement increases   |
| <input type="checkbox"/> Adding performing provider to an existing group   | <input type="checkbox"/> Incentive programs  | <input type="checkbox"/> Timely reimbursement  |  |
| <input type="checkbox"/> Electronic claims processing  | <input type="checkbox"/> Learned about Texas State Health-Care Programs at a conference        |  |  |

\* Providers **must** enter the physical address **where the services are rendered to clients**. If the accounting, corporate, or mailing address is entered in the physical address field, the application may be denied.

**Children’s Health Insurance Program (CHIP)**

Are you enrolling to provide services exclusively to CHIP clients?  Yes  No

I would like my information to be visible on the Texas Medicaid Online Provider Lookup (OPL).  Yes  No

**Healthy Texas Women (HTW)**

Choose one of the following:

- I do not provide services for HTW clients.
- I provide services for HTW clients. (If you provide services for HTW clients, you must complete the Healthy Texas Women Certification in Appendix A.)





**Note.** If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

## Backup Withholding

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

## What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

## Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

**Note. ITIN applicant:** Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

**Line 2**

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

**Line 3**

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

**Limited Liability Company (LLC).** If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

**Line 4, Exemptions**

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

**Exempt payee code.**

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| IF the payment is for . . .  | THEN the payment is exempt for . . .  |
|--|---|
| Interest and dividend payments   | All exempt payees except for 7  |
| Broker transactions  | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012. |
| Barter exchange transactions and patronage dividends                                   | Exempt payees 1 through 4   |
| Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup> | Generally, exempt payees 1 through 5 <sup>2</sup>   |
| Payments made in settlement of payment card or third party network transactions        | Exempt payees 1 through 4   |

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

**Exemption from FATCA reporting code.** The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

- A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B—The United States or any of its agencies or instrumentalities
- C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)
- E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)
- F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G—A real estate investment trust
- H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I—A common trust fund as defined in section 584(a)
- J—A bank as defined in section 581
- K—A broker
- L—A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

**Note.** You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

**Line 5**

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

**Line 6**

Enter your city, state, and ZIP code.

**Part I. Taxpayer Identification Number (TIN)**

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [IRS.gov](http://IRS.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

**Part II. Certification**

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

**Signature requirements.** Complete the certification as indicated in items 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

**What Name and Number To Give the Requester**

| For this type of account:   | Give name and SSN of:   |
|---|---|
| 1. Individual   | The individual  |
| 2. Two or more individuals (joint account)  | The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup> |
| 3. Custodian account of a minor (Uniform Gift to Minors Act)  | The minor <sup>2</sup>  |
| 4. a. The usual revocable savings trust (grantor is also trustee)<br>b. So-called trust account that is not a legal or valid trust under state law  | The grantor-trustee <sup>1</sup><br><br>The actual owner <sup>1</sup>                                   |
| 5. Sole proprietorship or disregarded entity owned by an individual   | The owner <sup>3</sup>  |
| 6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i) (A))   | The grantor <sup>*</sup>  |
| For this type of account:   | Give name and EIN of:   |
| 7. Disregarded entity not owned by an individual  | The owner   |
| 8. A valid trust, estate, or pension trust  | Legal entity <sup>4</sup>   |
| 9. Corporation or LLC electing corporate status on Form 8832 or Form 2553   | The corporation   |
| 10. Association, club, religious, charitable, educational, or other tax-exempt organization   | The organization  |
| 11. Partnership or multi-member LLC   | The partnership   |
| 12. A broker or registered nominee  | The broker or nominee   |
| 13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity   |
| 14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i) (B))   | The trust   |

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

**\*Note.** Grantor also must provide a Form W-9 to trustee of trust.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

**Secure Your Tax Records from Identity Theft**

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

**Protect yourself from suspicious emails or phishing schemes.** Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft) or 1-877-IDTHEFT (1-877-438-4338).

Visit [IRS.gov](http://IRS.gov) to learn more about identity theft and how to reduce your risk.

**Privacy Act Notice**

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

# Provider Information Form (5 Pages)

## Instructions

Each Provider must complete this Provider Information Form 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).

All high-categorical risk level providers must submit fingerprints for enrollment or revalidation in Texas Medicaid.

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 or other State Health-Care Program Agreement.

## Definitions

A “Provider” is any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS 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.

|  |   |                                      |  |               |  |
|--|---|--------------------------------------|--|---------------|--|
| <b>Driver’s License No.:</b>                                 |   | <b>Expiration Date:</b>              |  | <b>State:</b> |  |
| <b>Gender:</b>   | <input type="checkbox"/> Male <input type="checkbox"/> Female |                                      |  |               |  |
| <b>Medicare Provider No.:</b>                                |   | <b>Medicare Certification Date:</b>  |  |               |  |
| <b>Professional License / Certification / Accreditation:</b> |   |                                      |  |               |  |
| <b>1.</b>  | <b>Professional Licensing or Certification Board:</b>         |                                      | <b>Licensing State:</b>                            |               |  |
|  |   |                                      |  |               |  |
|  | <b>License Accreditation Certification Issuer:</b>            |                                      | <b>License Accreditation Certification Number:</b> |               |  |
|  |   |                                      |  |               |  |
| <b>Issue Date (mm/dd/yyyy):</b>                              |   | <b>Expiration Date (mm/dd/yyyy):</b> |  |               |  |
|  |   |                                      |  |               |  |
| <b>2.</b>  | <b>Professional Licensing or Certification Board:</b>         |                                      | <b>Licensing State:</b>                            |               |  |
|  |   |                                      |  |               |  |
|  | <b>License Accreditation Certification Issuer:</b>            |                                      | <b>License Accreditation Certification Number:</b> |               |  |
|  |   |                                      |  |               |  |
| <b>Issue Date (mm/dd/yyyy):</b>                              |   | <b>Expiration Date (mm/dd/yyyy):</b> |  |               |  |
|  |   |                                      |  |               |  |

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|           |   |  |
|-----------|---|--|
| <b>3.</b> | <b>Professional Licensing or Certification Board:</b> | <b>Licensing State:</b>                            |
|           |   |  |
|           | <b>License Accreditation Certification Issuer:</b>    | <b>License Accreditation Certification Number:</b> |
|           |   |  |
|           | <b>Issue Date (mm/dd/yyyy):</b>                       | <b>Expiration Date (mm/dd/yyyy):</b>               |
|           |   |  |

|   |                                 |                                      |
|---|---------------------------------|--------------------------------------|
| <b>Supervising /Consulting/Referring Physician License Number and State (if required by your licensing or certification board):</b> | <b>Issue Date: (mm/dd/yyyy)</b> | <b>Expiration Date: (mm/dd/yyyy)</b> |
|   |                                 |                                      |

**CLIA Certification Number:** (attach a copy of the CLIA certification, if applicable)  
Hospitals providing laboratory services, and independent laboratories (including those located in physician’s offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at [www.cms.gov](http://www.cms.gov).

**CLIA Certification Address:** (list the address listed on the CLIA Certificate, if applicable)

|        |        |       |      |       |     |
|--------|--------|-------|------|-------|-----|
| Number | Street | Suite | City | State | ZIP |
|        |        |       |      |       |     |

|   |  |
|---|--|
| <b>CLIA Certification Effective Date (if applicable):</b> | <b>CLIA Certification Expiration Date (if applicable):</b> |
|   |  |

**Previous Physical Address:**

|        |        |       |      |       |     |
|--------|--------|-------|------|-------|-----|
| Number | Street | Suite | City | State | ZIP |
|        |        |       |      |       |     |

**Previous Accounting Address:**

|        |        |       |      |       |     |
|--------|--------|-------|------|-------|-----|
| Number | Street | Suite | City | State | ZIP |
|        |        |       |      |       |     |

**Do you plan to use a Third Party Biller to submit your health-care claims?**       Yes     No

If “Yes,” provide the following information about the billing agent.

|                               |                          |
|-------------------------------|--------------------------|
| <b>Billing Agent Name:</b>    | <b>Address:</b>          |
|                               |                          |
| <b>Federal Tax ID Number:</b> |                          |
|                               |                          |
| <b>Contact Person Name:</b>   | <b>Telephone Number:</b> |
|                               |                          |

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List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. (Attach additional sheets if necessary)

|           |                          |                                |                                    |      |           |
|-----------|--------------------------|--------------------------------|------------------------------------|------|-----------|
| <b>1.</b> | <b>Name:</b>             | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |      |           |
|           |                          |                                |                                    |      |           |
|           | <b>Physical Address:</b> |                                |                                    |      |           |
|           | Number                   | Street                         | Suite                              | City | State ZIP |
|           |                          |                                |                                    |      |           |
|           | <b>Federal Tax ID:</b>   | <b>TPI:</b>                    | <b>NPI/API:</b>                    |      |           |
|           |                          |                                |                                    |      |           |
| <b>2.</b> | <b>Name:</b>             | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |      |           |
|           |                          |                                |                                    |      |           |
|           | <b>Physical Address:</b> |                                |                                    |      |           |
|           | Number                   | Street                         | Suite                              | City | State ZIP |
|           |                          |                                |                                    |      |           |
|           | <b>Federal Tax ID:</b>   | <b>TPI:</b>                    | <b>NPI/API:</b>                    |      |           |
|           |                          |                                |                                    |      |           |
| <b>3.</b> | <b>Name:</b>             | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |      |           |
|           |                          |                                |                                    |      |           |
|           | <b>Physical Address:</b> |                                |                                    |      |           |
|           | Number                   | Street                         | Suite                              | City | State ZIP |
|           |                          |                                |                                    |      |           |
|           | <b>Federal Tax ID:</b>   | <b>TPI:</b>                    | <b>NPI/API:</b>                    |      |           |
|           |                          |                                |                                    |      |           |
| <b>4.</b> | <b>Name:</b>             | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |      |           |
|           |                          |                                |                                    |      |           |
|           | <b>Physical Address:</b> |                                |                                    |      |           |
|           | Number                   | Street                         | Suite                              | City | State ZIP |
|           |                          |                                |                                    |      |           |
|           | <b>Federal Tax ID:</b>   | <b>TPI:</b>                    | <b>NPI/API:</b>                    |      |           |
|           |                          |                                |                                    |      |           |
| <b>5.</b> | <b>Name:</b>             | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |      |           |
|           |                          |                                |                                    |      |           |
|           | <b>Physical Address:</b> |                                |                                    |      |           |
|           | Number                   | Street                         | Suite                              | City | State ZIP |
|           |                          |                                |                                    |      |           |
|           | <b>Federal Tax ID:</b>   | <b>TPI:</b>                    | <b>NPI/API:</b>                    |      |           |
|           |                          |                                |                                    |      |           |

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|  |   |
|--|---|
| <p>“Sanction” is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.</p> <p><b>Have you ever been sanctioned (as defined above) in any state or federal program?</b></p>  | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <p><i>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)</i></p>  |   |
| <p><b>Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?</b></p> <p><b>Have you ever had your professional healthcare license or certification revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?</b></p> <p><b>Have you ever voluntarily surrendered a professional healthcare license or certification in lieu of disciplinary action?</b></p> <p><i>(You may be subject to a license or certification verification/status check with your licensing or certification board.)</i></p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p><i>If “Yes” was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (Attach additional sheets if necessary)</i></p>   |   |
| <p><b>Have you ever enrolled in or applied to any other State’s Medicaid or CHIP program?</b></p> <p><b>Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?</b></p> <p><b>Do you currently have any outstanding debt or have you received notice of an unpaid amount due in relation to any State or Federally funded program?</b></p>   | <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <p><i>If “Yes” was answered to any of the questions, fully explain the details including date, and the state if applicable.</i></p>  |   |

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|  |   |
|--|---|
| <p>“Convicted” means that:</p> <ul style="list-style-type: none"> <li>(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:             <ul style="list-style-type: none"> <li>(1) There is a post-trial motion or an appeal pending, or</li> <li>(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;</li> </ul> </li> <li>(b) A Federal, State or local court has made a finding of guilt against an individual or entity;</li> <li>(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or</li> <li>(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.</li> </ul> <p><b>Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?</b></p> <p><i>To answer this question, use the federal Medicaid/Medicare definition of “Convicted” in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.</i></p> <p><b>Have you been arrested for a crime but not yet charged or is there an outstanding warrant for your arrest?</b></p> | <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> |
| <p><i>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.)</i></p>  |   |
| <p><b>Are you currently subject to court-ordered child support payments?</b></p> <p><i>If “Yes,” provide details.</i></p>  | <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>   |
| <p><b>Are you currently behind 30 days or more on court ordered child support payments?</b></p> <p><i>If “Yes,” provide details of how these past-due payment obligations will be met. (Attach additional sheets if necessary.)</i></p>  | <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>   |
| <p><b>Are you a citizen of the United States?</b></p> <p><i>If “No,” provide the country of which you are a citizen.</i></p>   | <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>   |
| <p><b>If you are not a citizen of the United States, do you have a legal right to work in the United States?</b></p> <p><i>If “Yes,” attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.</i></p>  | <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>   |

**Fingerprint Criminal Background Check (FCBC) for High-Categorical Risk Providers**

I acknowledge that I am required to submit proof of fingerprinting, if it is determined I meet the requirement to be assigned a high screen risk category.

# Electronic Funds Transfer (EFT) Notification (5 Pages)

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## Instructions

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a provider's bank account. These funds can be credited to either checking or savings accounts, if the provider's bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by *ensuring funds are directly deposited into a specified account*.

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customer's needs.

In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

**Important:** *Submit the completed Electronic Funds Transfer (EFT) Notification form with a copy of a voided check or signed letter from your bank. Call the **TMHP Contact Center** at **1-800-925-9126** if you need assistance.*

Return this form to:

Texas Medicaid & Healthcare Partnership  
ATTN: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795

## Electronic Funds Transfer (EFT) Notification

By submitting a signed copy of the EFT Notification form I agree to the following:

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

As part of the EFT enrollment process and to comply with the Affordable Care Act CAQH CORE Rule 370, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. These data elements will allow you to easily associate your EFT payment with the appropriate ERA remittance advice. You may read more about the CAQH CORE Rule at the CAQH website: <http://caqh.org/>

Complete the required fields on the EFT Notification form as follows:

| <b>Provider Information</b>  |   |
|--|---|
| Provider Name  | Enter the provider's legal name according to the Internal Revenue Service (IRS).  |
| Provider Address   | Enter the provider's address including the street, city, state/province and ZIP code/postal code.                         |
| <b>Provider Identifiers Information</b>  |   |
| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) | Enter the provider's TIN or EIN.  |
| National Provider Identifier (NPI)   | Enter the provider's NPI.   |
| Other Identifier(s)  | The Billing TPI and other related TPIs (up to a total of nine) for this enrollment.                                       |
| Assigning Authority  | Organization that issues and assigns the additional identifier requested on the form, e.g., Medicare, Medicaid.           |
| <b>Financial Institution Information</b>   |   |
| Financial Institution Name   | Enter the name of the provider's financial institution  |
| Financial Institution Address:   | Enter the provider's financial institution's address including the street, city, state/province and ZIP code/postal code. |
| Financial Institution Routing Number   | Enter the 9-digit routing identifier of the financial institution where EFT payments are to be deposited.                 |
| Type of Account at Financial Institution   | Enter the type of account the provider will use to receive EFT payments (e.g., checking, saving).                         |
| Provider's Account Number with Financial Institution                                     | Enter the provider's account number at the financial institution where EFT payments are to be deposited.                  |
| Account Number Linkage to Provider Identifier  | Enter the provider's preference for grouping (bulking) claim payments.  |

## Electronic Funds Transfer (EFT) Notification

| Submission Information   |  |
|--|--|
| Reason for Submission  | <p>Select the most appropriate reason for submission of the EFT Notification form:</p> <ul style="list-style-type: none"> <li>New Enrollment (New EFT request)</li> <li>Change Enrollment (EFT change request)</li> <li>Cancel Enrollment (EFT cancellation request)</li> </ul> <p><b>Re-enrolling Providers:</b><br/>You must select the “Change Enrollment” box in the Reason for Submission field.</p> <p>If you are already signed up for EFT, you can use your existing EFT information to complete this form. If you don’t complete this form, your EFT enrollment will be canceled. If you complete the form using different EFT information, your EFT payments will be delayed while we setup a new account.</p> |
| Include with Enrollment Submission   | Select which document is included with the EFT Notification form.  |
| Authorized Signature   |  |
| Written Signature of Person Submitting Enrollment  | Signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.   |
| Submission Date  | Enter the date the EFT Notification form was signed.   |
| Printed Name of Person Submitting Enrollment   | Enter the printed name of the person signing the EFT Notification form.  |
| Printed Title of Person Submitting Enrollment  | Enter the printed title of the person signing the EFT Notification form.   |
| Requested EFT Start/Change/Cancel Date   | Enter the date on which the requested action is to begin.  |
| Other Data Elements  |  |
| <p>The other data elements within this form will allow providers to easily associate EFT and Electronic Remittance Advice (ERA) transactions.</p> <p>Refer to the Council for Affordable Quality Healthcare (CAQH) website, <a href="http://caqh.org/">http://caqh.org/</a> for more information about CORE Rule 370 and the other data elements on the EFT Notification form.</p> |  |

## Electronic Funds Transfer (EFT) Notification

| Provider Information |                              |  |
|----------------------|------------------------------|--|
| Provider Name *      | Doing Business As Name (DBA) |  |
|                      |                              |  |
| Provider Address     |                              |  |
| Street *             | City *                       | State/Province * ZIP Code/Postal Code * Country Code |
|                      |                              |  |

| Provider Identifiers Information   |                                      |
|--|--------------------------------------|
| Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) * | National Provider Identifier (NPI) * |
|  |                                      |
| Other Identifier(s) *  | Assigning Authority *                |
|  |                                      |
| Trading Partner ID   |                                      |
|  |                                      |
| Provider License Number  | License Issuer                       |
|  |                                      |
| Provider Type  | Provider Taxonomy Code               |
|  |                                      |

| Provider Contact Information |                            |               |
|------------------------------|----------------------------|---------------|
| Provider Contact Name        | Title                      |               |
|                              |                            |               |
| Telephone Number             | Telephone Number Extension | Email Address |
|                              |                            |               |
| Fax Number                   |                            |               |
|                              |                            |               |

| Provider Agent Information  |                            |  |
|-----------------------------|----------------------------|--|
| Provider Agent Name         |                            |  |
|                             |                            |  |
| Agent Address               |                            |  |
| Street                      | City                       | State/Province ZIP Code/Postal Code Country Code |
|                             |                            |  |
| Provider Agent Contact Name | Title                      |  |
|                             |                            |  |
| Telephone Number            | Telephone Number Extension | Email Address                                    |
|                             |                            |  |
| Fax Number                  |                            |  |
|                             |                            |  |

\* Required field

# Electronic Funds Transfer (EFT) Notification

| Federal Agency Information        |                              |
|-----------------------------------|------------------------------|
| Federal Program Agency Name       |                              |
|                                   |                              |
| Federal Program Agency Identifier | Federal Agency Location Code |
|                                   |                              |

| Retail Pharmacy Information |                          |
|-----------------------------|--------------------------|
| Pharmacy Name               | Chain Number             |
|                             |                          |
| Parent Organization ID      | Payment Center ID        |
|                             |                          |
| NDCP Provider ID Number     | Medicaid Provider Number |
|                             |                          |

| Financial Institution Information                      |  |                            |                        |
|--|--|----------------------------|------------------------|
| Financial Institution Name *                           |  |                            |                        |
|  |  |                            |                        |
| Financial Institution Address                          |  |                            |                        |
| Street *   | City *   | State/Province *           | ZIP Code/Postal Code * |
|  |  |                            |                        |
| Financial Institution Telephone Number                 |  | Telephone Number Extension |                        |
|  |  |                            |                        |
| Financial Institution Routing Number *                 | Type of Account at Financial Institution *   |                            |                        |
|  |  |                            |                        |
| Provider's Account Number with Financial Institution * | Account Number Linkage to Provider Identifier *  |                            |                        |
|  | <input type="checkbox"/> Provider Tax Identification Number (TIN): _____<br><input type="checkbox"/> National Provider Identification (NPI): _____ |                            |                        |

| Submission Information  |   |
|---|---|
| Reason for Submission *   | Include with Enrollment Submission *  |
| <input type="checkbox"/> New Enrollment<br><input type="checkbox"/> Change Enrollment<br><input type="checkbox"/> Cancel Enrollment | <input type="checkbox"/> Voided Check<br><input type="checkbox"/> Bank Letter |

| Authorized Signature                                |   |
|---|---|
| Written Signature of Person Submitting Enrollment * |   |
|   |   |
| Printed Name of Person Submitting Enrollment *      | Printed Title of Person Submitting Enrollment * |
|   |   |
| Requested EFT Start/Change/Cancel Date *            | Submission Date *                               |
|   |   |

\* Required field

# Disclosure of Ownership Form (3 Pages)

This form is required for all individuals, groups, and facilities (excluding performing providers and SHARS providers).

|             |   |              |                          |  |           |
|-------------|---|--------------|--------------------------|--|-----------|
| <b>I.</b>   | <b>Identifying information</b>  |              |                          |  |           |
| (a)         | <b>Legal Name</b> <i>(according to the IRS):</i>  | <b>DBA:</b>  | <b>Telephone Number:</b> |  |           |
|             |   |              |                          |  |           |
|             | <b>Physical/Corporate Address:</b>  |              |                          |  |           |
|             | Number  | Street       | Suite                    | City   | State ZIP |
|             |   |              |                          |  |           |
| <b>II.</b>  | <b>Answer the following questions by checking Yes or No.</b>  |              |                          |  |           |
|             | <i>If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.</i>   |              |                          |  |           |
| (a)         | Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?  |              |                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |           |
| (b)         | Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months? <i>(Medicare providers only)</i>  |              |                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |           |
| <b>III.</b> | <b>Type of Entity</b> <i>(Select only one; must match entity on W9):</i>  |              |                          |  |           |
|             | <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership  |              |                          |  |           |
|             | <input type="checkbox"/> Limited liability company <i>(Enter the tax classification [C=C corporation, S=S corporation, P=partnership]):</i> _____   |              |                          |  |           |
|             | <input type="checkbox"/> Trust/estate <input type="checkbox"/> Other <i>(specify)</i> _____   |              |                          |  |           |
|             | <b>Do you have a 501(c)(3) Internal Revenue Exemption?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Providers who answer "yes" to the question "Do you have a 501(c)(3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status from the State Comptroller's Office.  |              |                          |  |           |
| (a)         | <b>List the names of any other person or entity with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.</b> <i>See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.</i> |              |                          |  |           |
|             | <b>1.</b>   | <b>Name:</b> | <b>Address:</b>          | <b>Federal Tax ID:</b>                                   |           |
|             |   |              |                          |  |           |
|             | <b>2.</b>   | <b>Name:</b> | <b>Address:</b>          | <b>Federal Tax ID:</b>                                   |           |
|             |   |              |                          |  |           |
|             | <b>3.</b>   | <b>Name:</b> | <b>Address:</b>          | <b>Federal Tax ID:</b>                                   |           |
|             |   |              |                          |  |           |

|     |   |                    |  |
|-----|---|--------------------|--|
| (b) | <b>Do you currently have a creditor with a security interest in a debt that is owed by you?</b>   |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|     | <b>Is the creditor(s) security interest protected by at least 5 percent of your property?</b>   |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|     | List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property. <i>All listed creditors must also complete a Principal Information Form (PIF-2).</i> |                    |  |
|     | <b>Last Name/Company Name:</b>  | <b>First Name:</b> | <b>Percent of Security Interest:</b>                     |
|     |   |                    |  |
|     |   |                    |  |
|     |   |                    |  |

|     |  |
|-----|--|
| (c) | <b>If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks. <i>Note: Each director identified in this section must also complete a PIF-2. All PIF-2 documents must be submitted with this application. Attach additional pages if needed.</i></b> |
|     | <b>Remarks:</b>  |

**Section B: Owners, Partners, Officers, Directors, and Principals**

**Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals (as defined in the Principal Information Form [PIF-2]) of the applicant and list the percentage of ownership, if applicable.** Total ownership should equal 100 percent unless otherwise noted in the instructions. If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect. *(Add additional pages if necessary.)*

|    |              |  |                          |  |
|----|--------------|--|--------------------------|--|
| 1. | <b>Name:</b> |  | <b>Percentage Owned:</b> |  |
| 2. | <b>Name:</b> |  | <b>Percentage Owned:</b> |  |
| 3. | <b>Name:</b> |  | <b>Percentage Owned:</b> |  |

|                      |  |  |
|----------------------|--|--|
| <b>IV. Ownership</b> |  |  |
| (a)                  | <b>Has there been a change in ownership or control within the last year?</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | <i>If "Yes," give date:</i>  |  |
| (b)                  | <b>Are you seeking enrollment due to change of ownership?</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | <i>If "Yes," give date:</i>  |  |
| (c)                  | <b>Do you anticipate any change of ownership or control within the year?</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | <i>If "Yes," give date:</i>  |  |
| (d)                  | <b>Do you anticipate filing for bankruptcy within the year? <i>(see provider agreement for additional information)</i></b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      | <i>If "Yes," give date:</i>  |  |
| (e)                  | <b>Are any of the new owners related to any of the former owners?</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                      |  |  |



|     |   |                    |  |
|-----|---|--------------------|--|
| (f) | <b>Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty? If “Yes,” please list the name of the former owners below.</b> |                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|     | <b>Last Name:</b>   | <b>First Name:</b> | <b>Middle Initial:</b>                                   |
|     |   |                    |  |
|     |   |                    |  |

|  |  |  |
|--|--|--|
| <b>V. Management</b>   |  |  |
| <b>Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?</b> |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>If “Yes,” give date of change in operations:</i>  |  |  |

|                     |   |  |
|---------------------|---|--|
| <b>VI. Staffing</b> |   |  |
| (a)                 | <b>Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|   |   |  |
|---|---|--|
| <b>VII. Affiliation</b>   |   |  |
| (a)   | <b>Is the provider identified in Section I. above chain affiliated?</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <i>If “Yes,” provide the name, address, and Federal Tax ID number of the chain’s corporate/home office:</i> |   |  |
|   | Name  | Address  |
|   |   | Federal Tax ID   |

|                       |  |  |
|-----------------------|--|--|
| <b>VIII. Capacity</b> |  |  |
| (a)                   | <b>Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years? (For Hospitals only)</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                       | <i>If “Yes,” give:</i> Year of change:   | Current Beds:      Prior Beds:                           |

|                                       |  |                                      |
|---------------------------------------|--|--------------------------------------|
| <b>IX. Disclosure of Relationship</b> |  |                                      |
| (a)                                   | <b>Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):</b> |                                      |
|                                       | <b>Provider/Principal 1:</b>   | <b>Has a Relationship as:</b>        |
|                                       |  | <b>To Provider/Principal Name 2:</b> |
|                                       |  |                                      |
|                                       |  |                                      |

**PLEASE NOTE:** When claiming “Corporation” providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form, original signature and notarized.
- Certificate of Formation, Certificate of Filing, Certificate of Authority, or Certificate of Registration.
- Franchise Tax Account Status, available at <https://mycpa.cpa.state.tx.us/coa/Index.html>.

# Principal Information Form (PIF-2) (6 Pages)

*Required for any person or entity that meets the definition of a “Principal” or “Subcontractor” as defined below.*

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a “NA” on the questions that do not apply to the Principal or Subcontractor.

All owners that have a 5 percent or more direct or indirect ownership interest in a provider that is assigned a high-categorical risk level must submit fingerprints for enrollment or revalidation in Texas Medicaid.

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

|  |        |       |  |  |     |
|--|--------|-------|--|--|-----|
| Check person or entity: <input type="checkbox"/> Person <input type="checkbox"/> Entity <i>If “Entity,” please complete the following information.</i>   |        |       |  |  |     |
| <b>Tax ID number as shown on the W9 IRS form:</b>  |        |       | <b>Legal name as shown on the W9 IRS form:</b> |  |     |
|  |        |       |  |  |     |
| <b>Company Name:</b>   |        |       |  |  |     |
|  |        |       |  |  |     |
| <b>Address as shown on the W9 IRS form:</b>  |        |       |  |  |     |
| Number   | Street | Suite | City   | State  | ZIP |
|  |        |       |  |  |     |
| <b>How is the entity organized to conduct business activities?</b> <i>Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental</i> |        |       |  |  |     |
|  |        |       |  |  |     |
| <b>Do you conduct business under an assumed name?</b><br><i>If Yes, provide the assumed name below.</i>  |        |       |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |     |
| Assumed Name:  |        |       |  |  |     |
|  |        |       |  |  |     |

|  |        |  |  |   |     |
|--|--------|--|--|---|-----|
| <i>If you selected "Person" above, please complete the following information.</i>  |        |  |  |   |     |
| <b>Last Name:</b>  |        |  | <b>First Name/Middle Initial:</b>                            |   |     |
|  |        |  |  |   |     |
| <b>Maiden Name:</b>  |        | <b>List any other alias, name, or form of your name ever used:</b> |  |   |     |
|  |        |  |  |   |     |
| <b>The following information must be completed by all Principals, Subcontractors, and Creditors. For additional names or addresses, attach pages as necessary.</b>   |        |  |  |   |     |
| Check principal or subcontractor: <input type="checkbox"/> Principal <input type="checkbox"/> Subcontractor  |        |  |  |   |     |
| <b>Physical Address:</b>   |        |  |  |   |     |
| Number   | Street | Suite  | City   | State   | ZIP |
|  |        |  |  |   |     |
| <b>Accounting/Billing Address:</b>   |        |  |  |   |     |
| Number   | Street | Suite  | City   | State   | ZIP |
|  |        |  |  |   |     |
| <b>If your accounting address is different than your physical address, indicate your relationship to the accounting address:</b>   |        |  |  |   |     |
| <input type="checkbox"/> Billing agent <input type="checkbox"/> Management company <input type="checkbox"/> Employer <input type="checkbox"/> Self <input type="checkbox"/> Other ( <i>explain below</i> ) |        |  |  |   |     |
| <i>If you chose "Other," please explain:</i>   |        |  |  |   |     |
|  |        |  |  |   |     |
| <b>Social Security Number:</b>   |        |  | <b>Federal Tax ID number:</b>                                |   |     |
|  |        |  |  |   |     |
| <b>Specialty of practice: (i.e., pediatrics, general practice, etc.)</b>   |        |  | <b>Medicare intermediary: (if applicable)</b>                |   |     |
|  |        |  |  |   |     |
| <b>Medicare provider number (if applicable):</b>   |        |  | <b>Medicare effective date (mm/dd/yyyy) (if applicable):</b> |   |     |
|  |        |  |  |   |     |
| <b>Driver's license number:</b>  |        | <b>State:</b>  | <b>Driver's license expiration date (mm/dd/yyyy):</b>        |   |     |
|  |        |  |  |   |     |
| <b>Date of birth (mm/dd/yyyy):</b>   |        | <b>Gender:</b>   |  | <input type="checkbox"/> Male <input type="checkbox"/> Female |     |
|  |        |  |  |   |     |

**Do you have one or more professional licenses, accreditations, or certifications?**

Yes  No *If "Yes," provide the following information.*

|    |   |  |
|----|---|--|
| 1. | <b>Professional Licensing or Certification Board:</b> | <b>Licensing State:</b>                            |
|    |   |  |
|    | <b>License Accreditation Certification Issuer:</b>    | <b>License Accreditation Certification Number:</b> |
|    |   |  |
|    | <b>Issue Date (mm/dd/yyyy):</b>                       | <b>Expiration Date (mm/dd/yyyy):</b>               |
|    |   |  |
| 2. | <b>Professional Licensing or Certification Board:</b> | <b>Licensing State:</b>                            |
|    |   |  |
|    | <b>License Accreditation Certification Issuer:</b>    | <b>License Accreditation Certification Number:</b> |
|    |   |  |
|    | <b>Issue Date (mm/dd/yyyy):</b>                       | <b>Expiration Date (mm/dd/yyyy):</b>               |
|    |   |  |
| 3. | <b>Professional Licensing or Certification Board:</b> | <b>Licensing State:</b>                            |
|    |   |  |
|    | <b>License Accreditation Certification Issuer:</b>    | <b>License Accreditation Certification Number:</b> |
|    |   |  |
|    | <b>Issue Date (mm/dd/yyyy):</b>                       | <b>Expiration Date (mm/dd/yyyy):</b>               |
|    |   |  |
| 4. | <b>Professional Licensing or Certification Board:</b> | <b>Licensing State:</b>                            |
|    |   |  |
|    | <b>License Accreditation Certification Issuer:</b>    | <b>License Accreditation Certification Number:</b> |
|    |   |  |
|    | <b>Issue Date (mm/dd/yyyy):</b>                       | <b>Expiration Date (mm/dd/yyyy):</b>               |
|    |   |  |

**Previous Physical address:**

Number      Street      Suite      City      State      ZIP

**Previous Accounting address:**

Number      Street      Suite      City      State      ZIP

**Your title in the provider organization for which enrollment is being sought:**

**Your duties to the provider organization (attach additional sheets if necessary):**

**Your role in the provider organization:** *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official, Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown: (attach additional sheets if necessary)*

**Effective date of your role in the provider organization (mm/dd/yyyy):**

**Do you have a relationship with a separate provider?** (If "Yes," explain relationship below)

Yes  No

Explain relationship with the separate provider:

**List all TPIs, provider names, and physical locations under which you have billed or in which you were a principal. Include current and previous TPIs (attach additional sheets if necessary):**

|  |
|--|
|  |
|--|

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. (Attach additional sheets if necessary.)

|                          |                        |                                |                                    |
|--------------------------|------------------------|--------------------------------|------------------------------------|
| <b>1.</b>                | <b>Name:</b>           | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |
|                          |                        |                                |                                    |
| <b>Physical Address:</b> |                        |                                |                                    |
|                          | Number      Street     | Suite                          | City      State      ZIP           |
|                          |                        |                                |                                    |
|                          | <b>Federal Tax ID:</b> | <b>TPI:</b>                    | <b>NPI/API:</b>                    |
|                          |                        |                                |                                    |
| <b>2.</b>                | <b>Name:</b>           | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |
|                          |                        |                                |                                    |
| <b>Physical Address:</b> |                        |                                |                                    |
|                          | Number      Street     | Suite                          | City      State      ZIP           |
|                          |                        |                                |                                    |
|                          | <b>Federal Tax ID:</b> | <b>TPI:</b>                    | <b>NPI/API:</b>                    |
|                          |                        |                                |                                    |
| <b>3.</b>                | <b>Name:</b>           | <b>Social Security Number:</b> | <b>Date of Birth (mm/dd/yyyy):</b> |
|                          |                        |                                |                                    |
| <b>Physical Address:</b> |                        |                                |                                    |
|                          | Number      Street     | Suite                          | City      State      ZIP           |
|                          |                        |                                |                                    |
|                          | <b>Federal Tax ID:</b> | <b>TPI:</b>                    | <b>NPI/API:</b>                    |
|                          |                        |                                |                                    |

|   |  |
|---|--|
| <p>“Sanction” is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.</p>   |  |
| <p><b>Have you ever been sanctioned (as defined above) in any state or federal program?</b></p>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><i>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)</i></p>   |  |
| <p><b>Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?</b></p>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><b>Have you ever had your professional healthcare license or certification revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?</b></p>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><b>Have you ever voluntarily surrendered a professional healthcare license or certification in lieu of disciplinary action?</b></p> <p><i>(You may be subject to a license or certification verification/status check with your licensing or certification board.)</i></p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><i>If “Yes” was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (Attach additional sheets if necessary)</i></p>            |  |
| <p><b>Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?</b></p>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><b>Do you currently have any outstanding debt or have you received notice of an unpaid amount due in relation to any State or Federally funded program?</b></p>  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p><i>If “Yes” was answered to any of the questions, fully explain the details including date, and the state if applicable.</i></p>   |  |

|   |   |
|---|---|
| <p>“Convicted” means that:</p> <p>(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:</p> <ol style="list-style-type: none"> <li>(1) There is a post-trial motion or an appeal pending, or</li> <li>(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;</li> </ol> <p>(b) A Federal, State or local court has made a finding of guilt against an individual or entity;</p> <p>(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or</p> <p>(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.</p> <p><b>Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?</b></p> <p><i>To answer this question, use the federal Medicaid/Medicare definition of “Convicted” in 42 CFR. §1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.</i></p> <p><b>Have you been arrested for a crime but not yet charged or is there an outstanding warrant for your arrest?</b></p> | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> |
| <p><i>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)</i></p>  |   |
| <p><b>Are you currently subject to court-ordered child support payments?</b></p>  | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |
| <p><i>If “Yes,” provide details.</i></p>  |   |
| <p><b>Are you currently behind 30 days or more on court ordered child support payments?</b></p>   | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |
| <p><i>If “Yes,” provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)</i></p>  |   |
| <p><b>Are you a citizen of the United States?</b></p>   | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |
| <p><i>If “No,” provide the country of which you are a citizen.</i></p>  |   |
| <p><b>If you are not a citizen of the United States, do you have a legal right to work in the United States?</b></p> <p><i>If “Yes,” attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.</i></p>   | <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>  |

# HHSC Medicaid Provider Agreement

|   |        |       |   |       |     |
|---|--------|-------|---|-------|-----|
| <b>Name of provider enrolling:</b>  |        |       |   |       |     |
|   |        |       |   |       |     |
| <b>Medicaid TPI: (if applicable)</b>  |        |       | <b>Medicare provider ID number: (if applicable)</b> |       |     |
|   |        |       |   |       |     |
| <b>Physical address (where health care is rendered): Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.</b> |        |       |   |       |     |
| Number  | Street | Suite | City  | State | ZIP |
|   |        |       |   |       |     |
| <b>Accounting/billing address: (if applicable)</b>  |        |       |   |       |     |
| Number  | Street | Suite | City  | State | ZIP |
|   |        |       |   |       |     |

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the Provider (Provider) agrees to comply with all terms and conditions of this Agreement.

## I. ALL PROVIDERS

### 1.1 Agreement and documents constituting Agreement.

The current *Texas Medicaid Provider Procedures Manual* (Provider Manual) may be accessed via the internet at [www.tmhp.com](http://www.tmhp.com). Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws governing or regulating Medicaid, and provider further acknowledges and agrees that the provider is responsible for ensuring that all employees and agents of the provider also comply. Provider agrees to acknowledge HHSC’s provision of enrollment processes and authority to make enrollment decisions as found in Title 1, Part 15, Chapter 352 of the Texas Administrative Code. Provider is specifically responsible for ensuring that the provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to waste, abuse and fraud, and provider acknowledges and agrees that the provider and its principals will be held responsible for violations of this Agreement through any acts or omissions of the provider, its employees, and its agents. For purposes of this Agreement, a principal of the provider includes all owners with a direct or indirect ownership or control interest of five percent or more, all corporate officers and directors, all limited and non-limited partners, and all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company. Principals of the provider further include managing employee(s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

### 1.2 State and Federal regulatory requirements.

1.2.1 By signing this Agreement, Provider certifies that the provider and its principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal health-care program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 48 CFR, Ch. 3, relating to eligibility for federal contracts and grants.

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General’s Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent 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, provider licensure, certification, or accreditation, phone number, or provider business addresses. Changes due to a change of ownership or control interest must be reported to HHSC or its designee within 30 days of the change. All other changes must be reported to HHSC or its designee within 90 days of the change.

Provider agrees to disclose all convictions of Provider or Provider’s principals within ten business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of “Convicted” contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Send the information to the Texas Health and Human Services Commission’s Office of Inspector General, P.O. Box 85211 – Mail Code 1361, Austin, Texas 78708. Fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s).

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC’s



agent, the Texas Attorney General's Medicaid Fraud Control Unit, the Texas Department of Family and Protective Services (DFPS), the Texas Department of State Health Services (DSHS) and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all investigations are resolved and closed, or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC 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 their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1667. Provider understands and agrees that payment for goods and services under this Agreement is conditioned on the existence of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If provider fails to create, maintain, or produce such records in full accordance with this Agreement, provider acknowledges, agrees, and understands that the public monies paid the provider for the services are subject to 100 percent recoupment, and that the provider is ineligible for payment for the services either under this Agreement or under any legal theory of equity.

- 1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, the Texas Health and Human Services Commission's Office of Inspector General, and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors, and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or 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 agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the Texas Health and Human Services Commission's Office of Inspector General or its designee. Subcontractors include those persons and entities that provide medical or dental goods or services for which the Provider bills the Medicaid program, and those who provide billing, administrative, or management services in connection with Medicaid-covered services.
- 1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid 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 Medicaid 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 grant Medicaid 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 Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.
- 1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.
- 1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.
- 1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

### 1.3 Claims and encounter data.

- 1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payer, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.
- 1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.
- 1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement.
- 1.3.4 Federal and state law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

- 1.3.5 As a condition of eligibility for Medicaid benefits, a client assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC’s third-party recovery rules (*Texas Administrative Code* Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).
- 1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent, and to implement an effective method to track submitted claims against payments made by HHSC or its agents.
- 1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.
- 1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.
- 1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider’s employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the Texas Health and Human Services Commission’s Office of Inspector General. To report waste, abuse or fraud, go to [www.hhs.state.tx.us](http://www.hhs.state.tx.us) and select “Reporting Waste, Abuse, or Fraud”. Individuals may also call the Office of Inspector General hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

**II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS**

- 2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:
  - (a) The individual’s right to self-determination in making health-care decisions;
  - (b) The individual’s rights under the Natural Death Act (Health and Safety Code, Chapter 166) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;
  - (c) The individual’s rights under Health and Safety Code, Chapter 166, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,
  - (d) The individual’s rights to execute a Durable Power of Attorney for Health Care under the Probation Code, Chapter XII, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.
- 2.2 The Provider must have a policy regarding the implementation of the individual’s rights and compliance with state and federal laws.
- 2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual’s medical record.
- 2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.
- 2.5 The Provider must provide written information to all adult clients on the provider’s policies concerning the client’s rights.
- 2.6 The Provider must provide education for staff and the community regarding advance directives.

**III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS**

- 3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:
  - (a) School health and related services (SHARS)
  - (b) Case management for blind and visually impaired children (BVIC)
  - (c) Case management for early childhood intervention (ECI)
  - (d) Service coordination for intellectual and developmental disabilities (IDD)
  - (e) Service coordination for mental health (MH)
  - (f) Mental health rehabilitation (MHR)
  - (g) Tuberculosis clinics
  - (h) State hospitals

**IV. CLIENT RIGHTS**

- 4.1 Provider must maintain the client’s state and federal right of privacy and confidentiality to the medical and personal information contained in Provider’s records.
- 4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client’s acceptance of any service must be voluntary.
- 4.3 The client must have the right to choose any qualified provider of family planning services.

## V. THIRD PARTY BILLING VENDOR PROVISIONS

- 5.1 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 five working days of the initiation and termination of the contract and submitted in accordance with Medicaid 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 Providers failure to provide timely notice.
- 5.2 Provider must have a written 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. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid 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:
- (a) Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
  - (b) Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
  - (c) 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.
  - (d) Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or its contractor.
  - (e) 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 Medicaid program.
  - (f) Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
  - (g) Biller and Provider agree to notify the Medicaid program within five business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

## VI. TERM AND TERMINATION

- 6.1 If the correspondence/notice of enrollment from HHSC or its agent states a termination date, this Agreement terminates on that date with or without other advance notice of the termination date.
- 6.2 Provider may terminate this Agreement by providing at least 30 days written notice of intent to terminate.
- 6.3 HHSC has grounds for terminating this Agreement, including but not limited to, the circumstances listed below, and which may include the actions or circumstances involving the Provider or any person or entity with an affiliate relationship to the Provider:
- (a) the exclusion from participation in Medicare, Medicaid, or any other publically funded health-care program;
  - (b) the loss or suspension of professional license or certification;
  - (c) any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program;
  - (d) any circumstances indicating that the health or safety of clients is or may be at risk;
  - (e) the circumstances for termination listed in 42 C.F.R. § 455.416, as amended; and
  - (f) the circumstances for termination listed in 1 T.A.C. §371.1703, as amended.

The Provider will receive written notice of termination, which will include the detailed reasons for the termination. The written notice of termination will also inform the Provider its due process rights.

- 6.4 HHSC may also cancel this Agreement for reasons, including but not limited to, the following:
- (a) upon further review of the Provider's application, at any time during the term of this Agreement, HHSC or its agent, determines Provider is ineligible to participate in the Medicaid program; and the errors or omission cannot be corrected;
  - (b) if the Provider has not submitted a claim to the Medicaid program for at least 24 months; and
  - (c) any other circumstances resulting in Provider's ineligibility to participate in the Medicaid program.

The Provider will receive written notification of the cancellation of the Agreement and any rights to appeal HHSC's determination will be included.

## VII. ELECTRONIC SIGNATURES

- 7.1 Provider understands and agrees that any signature on a submitted document certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).
- 7.2 Provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

**VIII. COMPLIANCE PROGRAM REQUIREMENT**

- 8.1 By signing section VIII, Provider certifies that in accordance with requirement TAC 352.5(b)(11), Provider has a compliance program containing the core elements as established by the Secretary of Health and Human Services referenced in §1866(j)(9) of the Social Security Act (42 U.S.C. §1395cc(j)(9)), as applicable.

I attest that I have a compliance plan.  Yes  No

**IX. INTERNAL REVIEW REQUIREMENT**

- 9.1 Provider, in accordance with TAC 352.5 (b)(1), has conducted an internal review to confirm that neither the applicant or the re-enrolling provider, nor any of its employees, owners, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

I attest that an internal review was conducted to confirm that neither the applicant or the re-enrolling provider nor any of its employees, owners, managing partners, or contractors have been excluded from participation in a program under the Title XVIII, XIX, or XXI of the Social Security Act.  Yes  No

**X. PRIVACY, SECURITY, AND BREACH NOTIFICATION**

- 10.1 “Confidential Information” means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

- (a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);
- (b) Sensitive Personal Information (as defined in Texas Business and Commerce Code section 521.002);
- (c) Federal Tax Information (as defined in IRS Publication 1075);
- (d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);
- (e) Social Security Administration data;
- (f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

- 10.2 Any Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation the following:

- (a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;
- (b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;
- (c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;
- (d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;
- (e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;
- (f) OMB Memorandum M-07-16;
- (g) Texas Business and Commerce Code Chapter 521;
- (h) Texas Health and Safety Code, Chapters 181 and 611;
- (i) Texas Government Code, Chapter 552, as applicable; and
- (j) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

- 10.3 The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

- 10.4 Provider will ensure that any subcontractor of Provider who has access to HHSC Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider and Provider will submit a copy of that Business Associate Agreement to HHSC upon request.

**XI PROVIDER’S BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS**

- 11.1 For purposes of this section:

Breach has the meaning of the term as defined in 45 C.F.R. §164.402, and as amended.  
Discovery/Discovered has the meaning of the terms as defined in 45 C.F.R. §164.410, and as amended.

- 11.2 Notification to HHSC

- (a) Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any unauthorized disclosure or suspected disclosure of HHSC Confidential Information to the extent and in the manner determined by HHSC.
- (b) Provider’s obligation begins at discovery of unauthorized disclosure or suspected disclosure and continues as long as related activity continues, until all effects of the incident are mitigated to HHSC’s satisfaction (the “incident response period”).
- (c) Provider will require that its employees, owners, managing partners, or contractors or subcontractors (as applicable), comply with all of the following breach notice requirements.

### 11.3 Breach Notice:

#### 1. Initial Notice.

- (a) For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Member Information, within the first, consecutive clock hour of discovery, and for all other types of Confidential Information not more than 24 hours after discovery, *or in a timeframe otherwise approved by HHSC in writing*, initially report to HHSC's Privacy and Security Officers via email at: [privacy@HHSCC.state.tx.us](mailto:privacy@HHSCC.state.tx.us) and to the HHSC division responsible for this UMCC;
- (b) Report all information reasonably available to Provider about the privacy or security incident; and
- (c) Name, and provide contact information to HHSC for, Provider's single point of contact who will communicate with HHSC both on and off business hours during the incident response period.

### 11.4 48-Hour Formal Notice.

No later than 48 consecutive clock hours after discovery, or a time within which discovery reasonably should have been made by Provider, provide formal notification to HHSC, including all reasonably available information about the incident or breach, and Provider's investigation, including without limitation and to the extent available:

- (a) The date the incident or breach occurred;
- (b) The date of Provider's and, if applicable, its employees, owners, managing partners, or contractors or subcontractors discovery;
- (c) A brief description of the incident or breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);
- (d) A brief description of Provider's investigation and the status of the investigation;
- (e) A description of the types and amount of Confidential Information involved;
- (f) Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by Provider at that time;
- (g) Provider's initial risk assessment of the incident or breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHSC approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;
- (h) Provider's recommendation for HHSC's approval as to the steps individuals and/or Provider on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation Provider's provision of notifications, credit protection, claims monitoring, and any specific protections for a legally authorized representative to take on behalf of an Individual with special capacity or circumstances;
- (i) The steps Provider has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);
- (j) The steps Provider has taken, or will take, to prevent or reduce the likelihood of recurrence;
- (k) Identify, describe or estimate of the persons, workforce, subcontractor, or individuals and any law enforcement that may be involved in the incident or breach;
- (l) A reasonable schedule for Provider to provide regular updates to the foregoing in the future for response to the incident or breach, but no less than every three (3) business days or as otherwise directed by HHSC, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and
- (m) Any reasonably available, pertinent information, documents or reports related to an incident or breach that HHSC requests following discovery.

### 11.5 Investigation, Response and Mitigation.

- (a) Provider will immediately conduct a full and complete investigation, respond to the incident or breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHSC for incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC.
- (b) Provider will complete or participate in a risk assessment as directed by HHSC following an incident or breach, and provide the final assessment, corrective actions and mitigations to HHSC for review and approval.
- (c) Provider will fully cooperate with HHSC to respond to inquiries and/or proceedings by state and federal authorities, persons and/or incident about the incident or breach.
- (d) Provider will fully cooperate with HHSC's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such incident or breach, or to recover or protect any HHSC Confidential including complying with reasonable corrective action or measures, as specified by HHSC in a Corrective Action Plan if directed by HHSC under the UCCM.

### 11.6 Breach Notification to Individuals and Reporting to Authorities.

- (a) HHSC may direct Provider to provide breach notification to individuals, regulators or third-parties, as specified by HHSC following a breach.
- (b) Provider must obtain HHSC's prior written approval of the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in Provider's name and on Provider's letterhead, unless otherwise directed by HHSC, and will contain contact information, including the name and title of Provider's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.
- (c) Provider will provide HHSC with copies of distributed and approved communications.
- (d) Provider will have the burden of demonstrating to the satisfaction of HHSC that any notification required by HHSC was timely made. If there are delays outside of Provider's control, Provider will provide written documentation of the reasons for the delay.
- (e) If HHSC delegates notice requirements to Provider, HHSC shall, in the time and manner reasonably requested by Provider, cooperate and assist with Provider's information requests in order to make such notifications and reports.

**XII ACKNOWLEDGEMENTS AND CERTIFICATIONS**

12.1 By signing below, Provider acknowledges and certifies to all of the following:

- (a) Provider agrees to notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy no later than ten days after the case is filed. TMHP and HHSC also request notice of pleadings in the case.
- (b) Provider has carefully read and understands the requirements of this Agreement, and will comply.
- (c) Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the provider information forms (PIF-1) and principal information form (PIF-2), and provider certifies that this information is current, complete, and correct.
- (d) Provider agrees to review and update any information in the application to maintain compliance with and eligibility in the Medicaid program and continued participation therein.
- (e) Provider agrees to inform HHSC or its designee in writing of any changes to the information contained in the application, whether such changes occur before or after enrollment. The written notification must be within 30 calendar days of any changes in the information due to a change in ownership or control interests, and within 90 days of all other changes to the information previously submitted.
- (f) Provider agrees and understands that HHSC or its agent may review Provider’s application any time after the application has been accepted and for the term of this Agreement. Provider agrees and understands that upon review, HHSC or its designee may determine that the information contained therein does not meet the Medicaid program enrollment requirements and Provider may no longer be eligible to participate in the Program. Provider will have the opportunity to correct any errors or omissions as determined by HHSC or its agent. Provider agrees and understands that any errors or omissions that are not corrected or cannot be corrected will result in termination of this Agreement.
- (g) Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.
- (h) Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment, and may also result in other administrative sanctions that include payment hold, exclusion, debarment, termination of this Agreement, and monetary penalties.
- (i) Provider agrees to abide by all Medicaid regulations, program instructions, and Title XIX of the Social Security Act. The Medicaid laws, regulations, and program instructions are available through the Medicaid contractor. Provider understands that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider’s compliance with all applicable conditions of participation in Medicaid.

Name of Applicant: \_\_\_\_\_

Applicant’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For applicants that are entities, facilities, groups, or organizations, and an authorized representative is completing this application with authority to sign on the applicant’s behalf, the authorized representative must sign above and print their name and title where indicated below.

Representative’s Name: \_\_\_\_\_

Representative’s Position/Title: \_\_\_\_\_

# Final Checklist

**Important:** Only submit the completed pages of the application and any additional required forms and attachments. Do not submit the instruction pages of this application. They are for your reference only.

|   |
|---|
| <b>1. Complete the following required forms if applicable to your provider type and entity type — All items marked are required.</b>  |
| <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Texas Medicaid Identification Form</li> <li><input checked="" type="checkbox"/> Texas Medicaid Provider Enrollment Application</li> <li><input checked="" type="checkbox"/> HHSC Medicaid Provider Agreement</li> <li><input checked="" type="checkbox"/> Provider Information Form</li> <li><input checked="" type="checkbox"/> Principal Information Form (PIF-2) (A separate copy of this Principal Information Form (PIF-2) must be completed in full for <u>each</u> Principal, Subcontractor, and Creditor of the Provider, before enrollment) (performing providers are exempt)</li> <li><input checked="" type="checkbox"/> Disclosure of Ownership and Control Interest Statement Form</li> <li><input checked="" type="checkbox"/> IRS W-9 Form (performing providers are exempt)</li> <li><input type="checkbox"/> Corporate Board of Directors Resolution Form — <b>Must Be NOTARIZED</b></li> <li><input type="checkbox"/> Healthy Texas Women Certification</li> <li><input type="checkbox"/> Physician Relationship Agreement for Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs)</li> <li><input type="checkbox"/> Texas Medicaid Surety Bond Form (DME providers and non-government-operated ambulance providers only)</li> </ul> |
| <b>2. If applicable, complete and/or submit the following optional forms.</b>   |
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Electronic Funds Transfer (EFT) Notification and copy of a voided check or signed letter from the bank. (The signed letter from the bank must be on the bank's letterhead.)</li> <li><input type="checkbox"/> Texas Vaccines for Children (TVFC) Program Provider Agreement</li> <li><input type="checkbox"/> For CSHCN Services Program enrollment:             <ul style="list-style-type: none"> <li>• CSHCN Services Program Identification Form</li> <li>• Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program</li> <li>• Required Information for Designation as a Team Member or Affiliated Provider of a CSHCN Services Program Comprehensive Cleft/Craniofacial Team (as applicable)</li> <li>• Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider (as applicable)</li> </ul> </li> </ul>  |
| <b>3. Obtain signatures — These must be original signatures. Sworn Statements must be properly notarized by a Notary Public. All items checked are required forms for all providers.</b>  |
| <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> HHSC Medicaid Provider Agreement</li> <li><input checked="" type="checkbox"/> IRS W-9 Form</li> <li><input type="checkbox"/> Corporate Board of Directors Resolution Form — <b>Must Be NOTARIZED</b></li> <li><input type="checkbox"/> Electronic Funds Transfer (EFT) Notification</li> <li><input type="checkbox"/> Texas Vaccines for Children (TVFC) Program Provider Agreement</li> </ul>   |

#### 4. Attach all required documents

- Clinical Laboratory Providers** — Attach a copy of your CLIA certificate with approved specialty services as appropriate.
- Mammography Services Providers** — Attach a copy of the certification of your mammography systems from the Bureau of Radiation Control (BRC).
- Attach a copy of your approval letter or contract if required. (Refer to the Identification Form for provider types that require approval letter/contract.)
- Providers Incorporated In Texas** — Attach a copy of the following:
  - Corporate Board of Directors Resolution Form
  - Articles or Certification of Incorporation or Certificate of Fact
  - Certificate of Formation or Certificate of Filing
  - Franchise Tax Account Status
- Out-of-State Incorporated Providers** — Attach a copy of the following:
  - Corporate Board of Directors Resolution
  - Certification of Registration or Certificate of Authority
  - Franchise Tax Account Status
- Out-of-State Providers** — Attach proof of meeting one of the following criteria:
  - A medical emergency documented by the attending physician or other provider.
  - The client's health is in danger if he or she is required to travel to Texas.
  - Services are more readily available in the state where the client is located.
  - The customary or general practice for clients in a particular locality is to use medical resources in the other state.
  - All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency).
  - The services are medically necessary and the nature of the service is such that providers for this service are limited or not readily available within the state of Texas.
  - The services are medically necessary services to one or more dually eligible recipients (i.e., recipients who are enrolled in both Medicare and Medicaid)
  - The services are provided by a pharmacy that is a distributor of a drug that is classified by the U.S. Food and Drug Administration (FDA) as a limited distribution drug.
  - The services are medically necessary and one or more of the following exceptions for good cause exist and can be documented:
    - Texas Medicaid enrolled providers rely on the services provided by the applicant.
    - Applicant maintains existing agreements as a participating provider through one or more Medicaid managed care organizations (MCO) and enrollment of the applicant leads to more cost-effective delivery of Medicaid services.
  - A laboratory may participate as an in-state provider, regardless of the location where any specific service is performed or where the laboratory's facilities are located if:
    - The laboratory or an entity that is a parent, subsidiary, or other affiliate of the laboratory maintains laboratory operations in Texas;
    - The laboratory and each entity that is a parent, subsidiary, or other affiliate of the laboratory, individually or collectively, employ at least 1,000 persons at places of employment located in this state; and
    - The laboratory is otherwise qualified to provide the services under the program and is not prohibited from participating as a provider under any benefit programs administered by a health and human services agency, including HHSC, based on conduct that constitutes fraud, waste, or abuse.
- High-Categorical Risk Providers and Their Owners That Have 5 Percent or More Direct Ownership Interest:** Attach proof of fingerprinting for each required individual (*refer to the Enrollment Instructions*).



|  |
|--|
| <b>5. Include the application fee (if applicable) with the application.</b>  |
| <p>Make check, money order, or cashier's check payable in the appropriate amount to TMHP.</p> <p>Only paper checks, money orders, or cashier's checks in the amount of the CMS-directed fee will be accepted. Cash and electronic payments cannot be accepted. The application fee is a condition for enrollment. Applications cannot be processed without the fee.</p> <p>Application fee is not required and will not be accepted if the provider is enrolled in Medicare, another State's Medicaid program, or another Texas State agency. Providers will be required to submit details and/or payment of other programs or agencies to TMHP with submission of this application.</p> |
| <b>6. Make a copy for your records.</b>  |
| <p>Be sure to make a copy of all documents for your own records.</p>   |
| <b>7. Mail your application and all other required documents.</b>  |
| <p>Mail your application and all other required documents to the following address:</p> <p style="text-align: center;"> <b>Texas Medicaid &amp; Healthcare Partnership</b><br/> <b>ATTN: Provider Enrollment</b><br/> <b>P.O. Box 200795</b><br/> <b>Austin, TX 78720-0795</b> </p>  |

## **Appendix A: Additional Forms**

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The following forms must be attached to this application if applicable to the requested provider type:

- Corporate Board of Directors Resolution
- Physician Relationship Agreement for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers
- Healthy Texas Women Certification

# Corporate Board of Directors Resolution

THE FOLLOWING FORM IS FOR CORPORATIONS ONLY,  
AS INDICATED ON THE DISCLOSURE OF OWNERSHIP, QUESTION III (D).

State Of \_\_\_\_\_

County Of \_\_\_\_\_

On The \_\_\_\_\_ Day Of \_\_\_\_\_, 20\_\_\_\_\_, at a meeting of  
The Board Of Directors Of \_\_\_\_\_, A Corporation, held in the city of  
\_\_\_\_\_, in \_\_\_\_\_ county.

With A Quorum Of The Directors Present, The Following Business Was Conducted:

It was duly moved and seconded that the following resolution be adopted:  
Be it resolved that the board of directors of the above corporation do hereby authorize

\_\_\_\_\_ and his/her successors in office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Texas Health and Human Services Commission, and to execute said contract or contracts on behalf of the corporation, and further we do hereby give him/her the power and authority to do all things necessary to implement, maintain, amend, or renew said contract.

The above resolution was passed by a majority of those present and voting in accordance with the by-laws and Articles of Incorporation.

I certify that the above constitutes a true and correct copy of a part of the minutes of a meeting of the board of directors of

\_\_\_\_\_ held on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Secretary

Subscribed and Sworn Before Me, \_\_\_\_\_, a Notary Public for the County of \_\_\_\_\_, on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Stamp/Seal

Notary Public, County of \_\_\_\_\_

State of \_\_\_\_\_

Signature \_\_\_\_\_

**MESSAGE TO NOTARY:**  
**COMPLETE ALL OF THE BLANKS IN THIS**  
**NOTARY STATEMENT.**

# Physician's Letter of Agreement

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**Important:** *This form is required for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers.*

According to Texas Health and Human Services Commission (HHSC) rules 1 TAC 354.1253 (c) and 1 TAC 354.1252 (3), certified nurse midwife (CNM) providers and licensed midwife (LM) providers are required to inform HHSC in writing of the identity of a licensed physician or group of physicians with whom the CNM or LM has arranged for referral and consultation in the event of medical complications. For purposes of this rule, "consultation" means discussion of patient status, care, and management.

**Instructions:** Upon initial enrollment and upon revalidation every 5 years, the CNM or LM must complete and submit to TMHP with the Medicaid provider enrollment application the following agreement affirming the CNM's supervising physician arrangement or the LM's referring or consulting physician arrangement. A separate agreement must be submitted for each physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the physician.

A new agreement must also be completed and submitted to TMHP when a new arrangement is made and when changes to an arrangement are made. *The new agreement must be submitted to TMHP within 10 business days of a cancellation or change.* This agreement must be signed by the CNM or LM and the physician or physician group representative.

**Note:** *The physician group representative must be a physician in the group, and the license number provided must be the license number of the physician who signs the form. A non-physician cannot sign this form.*

|  |   |
|--|---|
| <b>Provider type:</b> <i>(choose one):</i>   | <b>Date agreement is effective with the referring/consulting/supervising physician:</b> |
| <input type="checkbox"/> Certified nurse midwife (CNM)<br><input type="checkbox"/> Licensed midwife (LM) |   |
| <b>CNM or LM Name:</b>   | <b>CNM or LM License Number:</b>  |
|  |   |
| <b>Referring/Consulting/Supervising Physician Name:</b>  | <b>Referring/Consulting/Supervising Physician License:</b>                              |
|  |   |

## Statement of Affirmation

I affirm that a formal agreement has been made between the physician or physician group identified above and the certified nurse midwife or licensed midwife identified above with regard to referral or consultation. All parties are in agreement that arrangements are in place to discuss the status and management of client care, and for client referral and acceptance of transfer of care if necessary.

CNM/LM Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send the completed agreement to the following address:

TMHP  
 Attn: TMHP Provider Enrollment Department  
 PO Box 200795  
 Austin, TX 78720-0795

# Healthy Texas Women Certification (3 Pages)

This certification pertains to the following Healthy Texas Women Program Provider:

Provider's Legal Name: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_

## DEFINITIONS

For the purposes of this certification, the following terms are defined as follows:

The term "Affiliate" means:

An individual or entity that has a legal relationship with another entity, which relationship is created or governed by at least one written instrument that demonstrates:

1. common ownership, management, or control; a franchise; or
2. the granting or extension of a license or other agreement that authorizes the Affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark.

The "written instruments" referenced above may include a certificate of formation, a franchise agreement, standards of affiliation, bylaws, articles of incorporation, or a license, but do not include agreements related to a physician's participation in a physician group practice, such as a hospital group agreement, staffing agreement, management agreement, or collaborative practice agreement.

The term "Abortion" has the meaning as defined in Texas Health and Safety Code §245.002.

The term "Promote" means advancing, furthering, advocating, or popularizing elective Abortion by, for example:

1. taking affirmative action to secure elective Abortion services for a Healthy Texas Women Program (HTW) client (such as making an appointment, obtaining consent for the elective Abortion, arranging for transportation, negotiating a reduction in an elective Abortion provider fee, or arranging or scheduling an elective Abortion procedure); however, the term does not include providing upon the patient's request neutral, factual information and nondirective counseling, including the name, address, telephone number, and other relevant information about a provider;
2. furnishing or displaying to a Healthy Texas Women Program client information that publicizes or advertises an elective Abortion service or provider; or
3. using, displaying, or operating under a brand name, trademark, service mark, or registered identification mark of an organization that performs or Promotes elective Abortions.

My name is \_\_\_\_\_. I am the provider or, if the provider is an organization,

I am the provider's \_\_\_\_\_ (title or position). I am of sound mind, capable of making this certification, and I am personally acquainted with the facts stated here. If I am representing an organizational provider, I am authorized to make this certification on the provider's behalf.

Throughout the remainder of this document, the word "I" will represent the individual provider that is completing this form or the organizational provider on whose behalf the form is being completed. If this form is being completed on behalf of an organizational provider, the word "I" is inclusive of the organization's owners, officers, employees, and volunteers, or any combination of these.

# Healthy Texas Women Certification

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By checking the boxes under each statement below, I affirm that each of the following statements is true. I understand that my failure to mark each of the statements will be regarded as my representation that the statement is false:

1. I do not perform or promote elective Abortions.  
 I affirm that this statement is true and correct.
2. I am not an Affiliate of an entity that performs or promotes elective Abortions.  
 I affirm that this statement is true and correct.
3. None of the funds that I receive for performing Healthy Texas Women Program services are used to pay the direct or indirect costs (including marketing, overhead, rent, phones and utilities) of Abortion procedures.  
 I affirm that this statement is true and correct.
4. None of the funds that I receive for performing Healthy Texas Women Program services are distributed to individuals or entities that perform elective Abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective Abortion procedures.  
 I affirm that this statement is true and correct.

**In addition, I understand and acknowledge that:**

- If I fail to complete and submit this certification, I will be disqualified from the Healthy Texas Women Program and the Texas Health and Human Services Commission (HHSC) will deny any claims I submit for Healthy Texas Women program services.
- If, after I submit this signed certification, I perform or agree to perform, or Promote elective Abortions, I will notify HHSC at least 30 calendar days before such action is taken. If I fail to notify HHSC as required, I will be disqualified from the HHSC Program and HHSC will deny any claims I submit for Healthy Texas Women Program services.
- If, while participating in the Healthy Texas Women Program, I perform or Promote an elective Abortion, I will be disqualified from the Healthy Texas Women Program, and HHSC will deny any claims I submit for Healthy Texas Women program services.
- If I submit this certification and agree to its terms, but HHSC determines that I am in fact ineligible to participate in the Healthy Texas Women Program, HHSC may place a payment hold on claims submitted by me or my organization for Healthy Texas Women Program services until HHSC can make a final determination regarding my eligibility.
- If HHSC determines that I am ineligible to receive funds under the Healthy Texas Women Program:
  - a) HHSC may recoup Healthy Texas Women Program funds paid on claims that I have incurred since the date the provider became ineligible;
  - b) HHSC will deny all Healthy Texas Women Program claims that I have submitted since the date of ineligibility; and
  - c) I will remain ineligible to participate in the Healthy Texas Women Program until I comply with the provisions of this certification form.
- If I knowingly make a false statement or misrepresentation on this certification, HHSC may consider me to have committed fraud or tampered with a government record under the laws of Texas, and I may be excluded from participation in the HHSC Healthy Texas Women Program.

# Healthy Texas Women Certification

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If statements 1 – 4 are marked “true,” the effective dates of your certification are as follows: (The effective date of the Certification spans from the contract start date through the end of the contract/project year.)

Effective Date of Certification: \_\_\_\_\_

**Note:** *Each Contractor must complete a new certification form annually and provide it to HHSC prior to execution of a Healthy Texas Women Program contract. The certification form will be provided to Contractors as a part of the contracting packet.*

**If, after certification, you can no longer affirm that any of statements 1 – 4 are true, you must request an immediate termination of your Healthy Texas Women Program certification.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_