# Provider Information Form (PIF-1)

## Instructions

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

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

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

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.

| **Name of Provider Enrolling** (*Group/Company name or Last, First, Middle Initial*)**:** | **Maiden Name:** |
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| | |

| **List any other alias, name, or form of your name ever used:** | **National Provider Identifier (NPI)** (*10-digit*)**:** |
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| **Primary Taxonomy Code** *(10-digit)***:** | |
| **Secondary Taxonomy Code*** (*10-digit*)**:** | |
| **Non-Texas-enrolled Taxonomy Code****:** | |

* *You may indicate up to 15 taxonomy codes; attach additional pages if needed.*

** *These codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid*

For additional names or addresses, attach pages as necessary.

| **Physical Address** (*where health care is rendered*)*: | | | | | |
|---|---|---|---|---|---|
| Number | Street | Suite | City | State | ZIP |
| | | | | | |
| **Accounting/Billing Address:** | | | | | |
| Number | Street | Suite | City | State | ZIP |
| | | | | | |

**If your accounting address is different than your physical address, indicate your relationship to the accounting address:**

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

*If you chose "Other," please explain:*

| **Social Security Number:** | **Federal Tax ID Number:** |
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| | |
| **Specialty of Practice** (*i.e., pediatrics, general practice, etc.*): | **Medicare Intermediary** (*if applicable*)**:** |
| | |
| **Medicare Provider Number** (*if applicable*)**:** | **Medicare Effective Date** (*mm/dd/yyyy*) (*if applicable*)**:** |
| | |

| **Driver's License Number:** | **State:** | **Driver's License Expiration Date** (*mm/dd/yyyy*)**:** |
|---|---|---|
| | | |

| **Date of Birth** (*mm/dd/yyyy*)**:** | | **Gender:** | ☐ Male ☐ Female |
|---|---|---|---|

* *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.*

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

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

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

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

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

**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.

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

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

| **CLIA Certification Effective Date** (*if applicable*): | **CLIA Certification Expiration Date** (*if applicable*): |
|---|---|
| | |

**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.*

| **Billing Agent Name:** | **Address:** |
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| | |
| **Federal Tax ID Number:** | |
| | |
| **Contact Person Name:** | **Telephone Number:** |
| | |

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

| | | | |
|---|---|---|---|
| **1.** | **Name:** | **Social Security Number:** | **Date of Birth** (*mm/dd/yyyy*)**:** |
| | | | |
| | **Physical Address:**<br>Number Street Suite City State ZIP | | |
| | | | |
| | **Federal Tax ID:** | **TPI:** | **NPI/API:** |
| | | | |
| **2.** | **Name:** | **Social Security Number:** | **Date of Birth** (*mm/dd/yyyy*)**:** |
| | | | |
| | **Physical Address:**<br>Number Street Suite City State ZIP | | |
| | | | |
| | **Federal Tax ID:** | **TPI:** | **NPI/API:** |
| | | | |
| **3.** | **Name:** | **Social Security Number:** | **Date of Birth** (*mm/dd/yyyy*)**:** |
| | | | |
| | **Physical Address:**<br>Number Street Suite City State ZIP | | |
| | | | |
| | **Federal Tax ID:** | **TPI:** | **NPI/API:** |
| | | | |
| **4.** | **Name:** | **Social Security Number:** | **Date of Birth** (*mm/dd/yyyy*)**:** |
| | | | |
| | **Physical Address:**<br>Number Street Suite City State ZIP | | |
| | | | |
| | **Federal Tax ID:** | **TPI:** | **NPI/API:** |
| | | | |
| **5.** | **Name:** | **Social Security Number:** | **Date of Birth** (*mm/dd/yyyy*)**:** |
| | | | |
| | **Physical Address:**<br>Number Street Suite City State ZIP | | |
| | | | |
| | **Federal Tax ID:** | **TPI:** | **NPI/API:** |
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| "Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.<br>**Have you ever been sanctioned (as defined above) in any state or federal program?** | ☐ Yes ☐ No |
| *If "Yes," fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (Attach additional sheets if necessary)* | |
| **Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?** | ☐ Yes ☐ No |
| **Have you ever had your professional healthcare license or certification revoked, suspended, or otherwise restricted, which includes all disciplinary and non-disciplinary actions?** | ☐ Yes ☐ No |
| **Have you ever voluntarily surrendered a professional healthcare license or certification in lieu of disciplinary action?**<br>*(You may be subject to a license or certification verification/status check with your licensing or certification board.)* | ☐ Yes ☐ No |
| *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)* | |
| **Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?** | ☐ Yes ☐ No |
| **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?** | ☐ Yes ☐ No |
| **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?** | ☐ Yes ☐ No |
| *If "Yes" was answered to any of the questions, fully explain the details including date, and the state if applicable.* | |

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| "Convicted" means that:<br>(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:<br>(1) There is a post-trial motion or an appeal pending, or<br>(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;<br>(b) A Federal, State or local court has made a finding of guilt against an individual or entity;<br>(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or<br>(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. | |
| **Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?**<br>*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.* | ☐ Yes ☐ No |
| **Have you been arrested for a crime but not yet charged or is there an outstanding warrant for your arrest?** | ☐ Yes ☐ No |
| *If "Yes," fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (Attach additional sheets if necessary.)* | |
| **Are you currently subject to court-ordered child support payments?** | ☐ Yes ☐ No |
| *If "Yes," provide details.* | |
| **Are you currently behind 30 days or more on court ordered child support payments?** | ☐ Yes ☐ No |
| *If "Yes," provide details of how these past-due payment obligations will be met. (Attach additional sheets if necessary.)* | |
| **Are you a citizen of the United States?** | ☐ Yes ☐ No |
| *If "No," provide the country of which you are a citizen.* | |
| **If you are not a citizen of the United States, do you have a legal right to work in the United States?**<br>*If "Yes," attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.* | ☐ Yes ☐ No |

## 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.