TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Medicaid
Enrollment Application

Facilities

INSTRUCTIONS
V. IV

Introduction

Dear Health-Care Professional:

Thank you for your interest in becoming a Texas Medicaid provider. Participation by providers in Texas Medicaid is vital to the successful delivery of Medicaid services, and we welcome your application for enrollment.

This application must be completed in its entirety as outlined in the instructions below and will be reviewed by the Texas Health and Human Services Commission (HHSC) and the claims contractor Texas Medicaid & Healthcare Partnership (TMHP).

Providers are encouraged to review the current *Texas Medicaid Provider Procedures Manual* for information about provider responsibilities, claims filing procedures, filing deadlines, benefits and limitations, and much more. The provider manual is updated monthly and can be accessed from the TMHP website at **www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx**.

There is no guarantee that your application will be approved for processing or that you will be assigned a Texas Provider Identifier (TPI). If you decide to provide services to a Medicaid client before your application has been approved, you do so with the understanding that, if your application is denied, Texas Medicaid will not pay the claims and that the law also prohibits you from billing the Medicaid client for the services that you provided.

Privacy Statement

With a few exceptions, Texas privacy laws and the Public Information Act entitle you to ask about the information collected on this application, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the Texas Administrative Code, 1 TAC §351.17-§ 351.23.

For questions concerning this notice or to request information or corrections, please contact Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at **1-800-925-9126**. TMHP customer service representatives are available Monday through Friday from 7 a.m. to 7 p.m. central standard time.

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the **physical address** listed on your application unless otherwise requested in the Contact Information section of this application.

Contact Information

For information about Medicaid provider identifier requirements, the status of your enrollment, or claims submission, call TMHP Contact Center toll-free at **1-800-925-9126**.

Thank you for your applying to become a Texas Medicaid provider.

Enrollment Requirements

Affordable Care Act

In compliance with the Affordable Care Act of 2010 (ACA), all providers are subject to ACA screening procedures for newly enrolling and re-enrolling providers. All participating providers must be screened upon submission of an application, including, but not limited to:

- Applications for providers that are new to Texas Medicaid.
- Applications for providers that are requesting new practice locations.
- Applications for currently enrolled providers that must periodically revalidate their enrollment in Texas Medicaid.

Refer to: Code of Federal Regulations (CFR) Title 42, Ch. IV, Part 455, Subpart E-Provider Screening and Enrollment; and Texas Administrative Code (TAC) Title 1, Part 15, Chapter 352, for the statutory provisions for these requirements.

Provider Screening

The Centers for Medicare & Medicaid Services (CMS) has defined three levels of risk: limited, moderate, and high. Categories are assigned to each provider type based on an assessment of the risk of fraud, waste, and abuse. HHSC has the authority to assign a risk level higher than that assigned by Medicare. HHSC assesses risk using criteria similar to that used by CMS, which includes trends of fraud, waste, and abuse specific to Texas provider types.

Fingerprint Criminal Background Check (FCBC)

All high-categorical risk level providers and their owners that have a 5 percent or more direct or indirect ownership interest must submit fingerprints for enrollment or revalidation in Texas Medicaid. If you have already submitted fingerprints for enrollment in Medicare, Texas Medicaid, or another state's Medicaid, please submit the proof of fingerprinting to the address listed in the Final Checklist (page 42 of the application).

Providers that are required to submit proof of fingerprinting must submit proof with this enrollment application. If proof of fingerprinting is not available at the time of submission, a six-digit service code will be provided when an application is submitted. This service code will be sent with a deficiency letter, and is required to schedule a fingerprinting appointment.

For more information about fingerprinting requirements or risk categories, please see the "*Provider Fingerprinting Requirement FAQs*" available under the "Helpful Links" section on the provider enrollment page of the TMHP website at **www.tmhp.com/Pages/ProviderEnrollment/PE_TX_Medicaid_New.aspx**.

Provider Revalidation

In compliance with ACA, all providers are required to revalidate their enrollment at least every three to five years depending on provider type. Providers will be notified that they are required to revalidate before their revalidation deadline. The ACA screening criteria applies during revalidation. Providers that do not revalidate their enrollment by the designated date will be disenrolled and will no longer receive reimbursement from Texas Medicaid.

Surety Bonds

DME suppliers are required to submit proof of a valid surety bond when submitting: 1) an initial enrollment application to enroll in Texas Medicaid, 2) an enrollment application to establish a new practice location, 3) an enrollment application for re-enrollment in Texas Medicaid.

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to the Department of State Health Services (DSHS).

The Surety Bond Form can be found on the provider forms page of the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**.

Facility Enrollment Application Instructions

All Providers

This application can be completed to enroll as a facility in Texas Medicaid, Texas Health Steps, and the Children with Special Health Care Needs (CSHCN) Services Program.

To ensure accurate processing, complete and return the following forms to TMHP:

- Medicare Enrollment Information Form (page 4 of the application)
- Application Payment Form (page 6 of the application)
- Texas Medicaid Identification Form (page 7 of the application)
- Provider of Services Information (page 9 of the application)
- IRS W-9 Form (performing providers exempt) (page 12 of the application)
- Provider Information Form (page 16 of the application)
- Disclosure of Ownership and Control Interest Statement Form (page 26 of the application)
- Principal Information Form (PIF-2) (page 29 of the application)
- HHSC Medicaid Provider Agreement (original signatures required) (page 35 of the application)

The following attachments must also be submitted if applicable for the requesting provider type:

- Copy of Certification of Mammography Systems from the Bureau of Radiation Control (for all providers rendering mammography services)
- Copy of CLIA Certificate with approved specialty services as appropriate
- Healthy Texas Women Certification (original signatures required)

Important: *Retain a copy for your records of all documents submitted for enrollment.*

Enrolling in Additional State Health-Care Programs

To enroll in other State health-care programs, the following applications are available on the provider forms page of the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**:

- Texas Medicaid Provider Enrollment Application Ordering and Referring Providers Only
- THSteps Dental Provider Enrollment Application
- Medical Transportation Program (MTP) Provider Enrollment Application
- Texas Vaccines for Children Program (TVFC)

Providers Incorporated In Texas

If the enrolling provider is **incorporated in Texas**, the following additional forms must be submitted:

- Corporate Board of Directors Resolution Form. This document must contain original signatures and be notarized.
- Articles or Certification of Incorporation or Certificate of Fact. If a corporation was formed before 2006, one of these certificates must be obtained from the Office of the Secretary of State.
- Certificate of Formation or Certificate of Filing. If a corporation was formed after 2006, one of these certificates must be obtained from the Office of the Secretary of State.
- Franchise Tax Account Status.

Refer to the instructions for “Appendix A” on page 16 for more information.

Out-of-State Incorporated Providers

If the enrolling provider is **incorporated in another state**, the following additional forms must be submitted:

- Corporate Board of Directors Resolution Form. This document must contain original signatures and be notarized.
- Certification of Registration or Certificate of Authority. One of these certificates must be obtained from the Office of the Secretary of State.
- Franchise Tax Account Status Page.

Refer to the instructions for "Appendix A" on page 16 for more information.

Enrollment Criteria for Out-of-State Providers

Out-of-state providers are subject to a limited enrollment term. You must submit proof of meeting one of the following criteria prior to being able to enroll with Texas Medicaid:

- 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 temporarily located.
- The customary or general practice for clients in a particular locality is to use medical resources in the other state (this is limited to providers located in a state bordering Texas).
- 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.

Instructions for Completing the Facility Application and Additional Forms

Medicare Enrollment Information

Medicare enrollment is a prerequisite for Medicaid enrollment if you render services for clients who are eligible for Medicare. If you have a Medicare number that pertains to this enrollment, you must supply the number to TMHP. If you do not have a Medicare number and are eligible for a Medicare Waiver Request, check the box for the waiver request that matches your situation (see page 4 of the application).

This information is required. Your enrollment in Texas Medicaid may be delayed if this section of the application is not completed at the time of submission.

Application Payment Form

Certain providers are required to submit an application fee. An application cannot be processed if the application fee is required and is not submitted with the application. For more information, please see the "*Provider Types Required to Pay an Application Fee*" available under the "Helpful Links" section on the provider enrollment page of the TMHP website at **www.tmhp.com/Pages/ProviderEnrollment/PE_TX_Medicaid_New.aspx**.

Texas Medicaid Identification Form

Type of Enrollment:

Choose the appropriate box to indicate if this is a new enrollment for a new provider, new provider type, new practice location, etc. or if this enrollment is in response to a re-enrollment letter.

Requesting Enrollment as:

Facility enrollment. This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers.

List NPI:

Enter your National Provider Identifier (NPI) in this box. An NPI is not required for Financial Management Services Agency (FMSA), Milk Donor Bank, Personal Assistance Services, and Service Responsibility Option (SRO) providers.

Additional Program Enrollment:

Children with Special Health Care Needs (CSHCN) Services Program. By checking this box, you are indicating that you would like to be considered for enrollment in the CSHCN Services Program. If this box is checked, you must also submit the following forms that are available on the CSHCN forms page of the TMHP website at **www.tmhp.com/Pages/CSHCN/CSHCN_Forms.aspx**:

- 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

Texas Health Steps Services (i.e., EPSDT). By checking this box, you are indicating that you wish to provide Texas Health Steps preventive medical checkups. If approved, you may be issued a Texas Health Steps medical provider identifier in addition to the provider identifier for your requested provider type.

If you elect *not* to enroll in Texas Health Steps at this time, you can enroll at a later date by submitting the Texas Health Steps Provider Enrollment Application, which is available on the provider forms page of the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**.

To enroll in the Texas Health Steps program, a provider must be a licensed physician (MD, DO); physician assistant (PA); clinical nurse specialist (CNS); nurse practitioner (NP); certified nurse midwife (CNM); federally qualified health centers (FQHC); health-care provider of a facility (public or private) capable of performing the required medical checkup procedures under the direction of a physician (such as a regional and local health department; family planning clinic; migrant health clinic; community-based hospital and clinic; maternity clinic; rural health clinic; home health agency; or school-based health center).

Texas Medicaid Identification Form

Texas Medicaid services are categorized by traditional services, case management services, and Comprehensive Care Program (CCP) services. Check the box with the appropriate category that identifies the provider type with which you are seeking enrollment. Check only the appropriate box to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to the instructions below.

Traditional Services

Ambulance/ Air Ambulance. To enroll in Texas Medicaid, ambulance providers must: 1) operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; 2) equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; 3) acquire a license from DSHS approving equipment and training levels of the crew; 4) enroll in Medicare. A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance TPI, not the hospital TPI.

You must attach a copy of your permit/license.

In addition, ambulance providers must disclose the Medical Director (a physician who is actively licensed by the Texas Medical Board). A PIF-2 will be required of the Medical Director.

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to the DSHS.

Ambulatory Surgical Center (ASC). To enroll in Texas Medicaid, ASCs must: meet and comply with applicable state and federal laws and provisions of the state plan under Title XIX of the Social Security Act for Medical Assistance, and be enrolled in Medicare. Out-of-state ASCs that are Medicare-certified as an ASC in the state where they are located and provide services to a Texas Medicaid client may be entitled to participate in Texas Medicaid.

Birthing Center. To enroll in Texas Medicaid, a birthing center must be licensed by DSHS. Texas Medicaid only reimburses birthing center services that provide a level of service equal to the professional skills of a physician, certified nurse-midwife (CNM), or licensed midwife (LM) who acts as the birth attendant. A birthing center is defined as a facility or institution where a woman is scheduled to give birth following an uncomplicated (low-risk) pregnancy. This term does not include a hospital, ambulatory surgical center, nursing facility, or residence of the woman giving birth.

You must attach a copy of your license.

Catheterization Lab. To enroll in Texas Medicaid, a catheterization lab must be Medicare-certified.

Chemical Dependency Treatment Facility. Chemical dependency treatment facilities licensed by licensed by HHSC or the appropriate state board where services are rendere are eligible to enroll in Texas Medicaid. Chemical dependency treatment facility services are those facility services determined by a qualified credentialed professional, as defined by the DSHS Chemical Dependency Treatment Facility Licensure Standards, to be reasonable and necessary for the care of clients of any age.

You must attach a copy of your license.

Community Mental Health Center. To enroll in Texas Medicaid, the provider must be actively enrolled in Medicare.

Comprehensive Health Center (CHC). To enroll in Texas Medicaid to provide medical services, physicians (MD and DO) and doctors (DMD, DDS, OD, DPM, and DC) must be licensed by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided. All physicians except pediatricians and physicians doing only THSteps medical screens must be enrolled in Medicare before Medicaid enrollment. Providers must submit a Medicare Waiver Request if their type of practice and service may never be billed to Medicare.

Comprehensive Outpatient Rehab Facility (CORF). To enroll in Texas Medicaid, a CORF must be Medicare-certified. CORFs are public or private institutions primarily engaged in providing, under medical direction, diagnostic, therapeutic, and restorative services to outpatients, and are required to meet specified conditions of participation.

Durable Medical Equipment (DME). A provider supplying medical equipment or appliances that are manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client's disability, condition, or illness. These providers must be Medicare-certified as a DME/medical supplier. Providers of customized, non-basic medical equipment, expendable medical supplies, and orthotic or prosthetic devices are also enrolled as a DME provider. Prescriptions, insulin, and insulin syringes are covered through the Medicaid Vendor Drug Program. Refer to the Pharmacy section for more information on pharmacies enrolled as Comprehensive Care Program (CCP) providers.

DME providers must purchase a surety bond as a condition of enrollment in Texas Medicaid. The State of Texas Medicaid Provider Surety Bond Form must be submitted with this application.

Family Planning Agency. Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. To enroll in Texas Medicaid, family planning agencies must ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician and have a medical director who is a physician currently licensed to practice medicine in Texas. Agencies must have an established record of performance in the provision of both medical and educational/counseling family planning services as verified through client records, established clinic hours, and clinic site locations; provide family planning services in accordance with DSHS standards of client care for family planning agencies; and be approved for family planning services by the DSHS Family Planning Program. Physicians who wish to provide Medicaid Obstetric and Gynecologic (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only TPI for OB-GYN services regardless of provider specialty. Similarly, federally qualified health centers do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC TPI using family planning procedure codes.

Federally Qualified Health Center/Federally Qualified Satellite/Federally Qualified Look-Alike. To enroll in Texas Medicaid, a Federally Qualified Health Center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. FQHC "look-alikes" are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers. A copy of the Public Health Service issued notice of grant award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to the TMHP Provider Enrollment Department annually. Centers are required to notify TMHP of all satellite centers that are affiliated with the parent FQHC and their actual **physical addresses**. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service–approved satellites using an Federally Qualified Satellite (FQS) TPI that ties back to the parent FQHC TPI and Federal Tax ID. This procedure allows for the parent FQHC to have one provider agreement as well as one cost report combining all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill Texas Medicaid directly, the center must have a separate TPI from the parent FQHC and will be required to file a separate cost report.

You must attach a copy of your grant award and the Federally Qualified Health Center Affiliation Affidavit. The form may be downloaded from the provider forms page of the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**.

Freestanding Psychiatric Facility. To be eligible to participate in CCP, a psychiatric hospital/facility must be accredited by the Joint Commission, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Facilities certified by Medicare must also meet the Joint Commission accreditation requirements. Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients ages 21-64.

Freestanding Rehabilitation Facility. To be eligible to participate in CCP, a freestanding rehabilitation hospital must be certified by Medicare, have a valid Provider Agreement with HHSC, and have completed the TMHP enrollment process. Texas Medicaid enrolls and reimburses freestanding rehabilitation hospitals for CCP services and Medicare deductible/coinsurance. The information in this section is applicable to CCP services only.

Genetics. Only full-service genetic providers may enroll in Texas Medicaid. Before enrolling, the provider must contract with DSHS for the provision of genetic services. Basic contract requirements are as follows. 1) The provider's medical director must be a clinical geneticist (MD or DO) who is board eligible/certified by the American Board of Medical Geneticists (ABMG). The physician must oversee the delivery and content of all medical services. 2) The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of at least the following professional staff. 3) The clinical geneticist (MD or DO) and at least one of the following: nurse, genetic associate, social worker, medical geneticist, or genetic counselor. Administrative personnel and support staff may also be involved. Additionally, each genetic professional providing clinical services must obtain a performing TPI from TMHP. For more contracting information, contact the DSHS Genetic Screening and Case Management Division at PO Box 149347, Austin, TX 78714-9347, Mail Code 1918, or call **1-800-252-8023**.

HCSSA. Home and Community Support Services Agency (HCSSA). An entity licensed by HHSC that provides home care, hospice, or personal assistance services for pay or other consideration in a client's residence, an independent living environment, or another appropriate location.

Refer to the Home Health section below for additional information about HCSSA enrollment for home health agencies.

Hearing Aid. To enroll in Texas Medicaid, hearing aid fitters and dispensers must be licensed by the licensing board of their profession to practice in the state where the services are performed at the time the services are provided. Audiologists and physicians who provide fitting and dispensing services should choose their respective provider type.

Home Health. Home health services (e.g., intermittent skilled nursing, physical therapy, occupational therapy and home health aide) are provided under Texas Medicaid as Title XIX services. To enroll, a provider must be a licensed HCSSA that is also Medicare certified. These facilities will have the Licensed and Certified Home Health (LCHH) category listed on the HHSC issued license. Home health providers may render traditional Title XIX Medicaid home health services, telemonitoring services, and CCP services.

Licensed Home Health-CCP. Licensed Home and Community Support Services Agencies (HCSSA) that are not Medicare certified, but have the licensed home health category on their HHSC issued license may provide only Private Duty Nursing, CCP therapy to children (0-20), telemonitoring services, or Personal Care Services (PCS) under Texas Medicaid Comprehensive Care Program. HCSSAs that also wish to provide Title XIX, Medicaid home health services must also be Medicare certified.

Note: *Home health providers with a category of service of hospice are not enrolled in Texas Medicaid.*

Hospital – In State. To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

Hospital Ambulatory Surgical Center (HASC). Hospitals certified and enrolled in Texas Medicaid are assigned a nine-character TPI (HASC) exclusively for billing day surgeries.

Hospital – Military. To enroll in Texas Medicaid, a military hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. Veteran's Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.

Hospital – Out of State. To be eligible to participate in Texas Medicaid, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

Hyperalimentation. To enroll in Texas Medicaid, providers of in-home total parental parenteral nutrition must be enrolled in Medicare (Palmetto) as in-home total parental hyperalimentation supplier providers.

Independent Diagnostic Testing Facility (IDTF). To enroll in Texas Medicaid, an IDTF provider must be actively enrolled in Medicare.

Independent Laboratory (No Physician involvement/Physician involvement). To enroll in Texas Medicaid, the independent (freestanding) laboratory must: 1) be independent from a physician's office or hospital; 2) meet staff, equipment, and testing capability standards for certification by HHSC; and 3) have Medicare certification.

Maternity Service Clinic (MSC). To enroll in Texas Medicaid, maternity service clinics (MSC) must ensure that the physician prescribing the services is employed by or has a contractual agreement/formal arrangement with the clinic to assume professional responsibility for the services provided to clinic patients. To meet this requirement a physician must see the patient at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care. Medicare certification is not a prerequisite for MSC enrollment. An MSC must: 1) be a facility that is not an administrative, organizational, or financial part of a hospital; 2) be organized and operated to provide maternity services to outpatients; 3) comply with all applicable federal, state, and local laws and regulations; 4) an MSC wanting to bill and receive reimbursement for case management services to high-risk pregnant adolescents, women, and infants must meet the criteria specified in the Case Management for Children and Pregnant Women section.

Opioid Treatment Provider (OTP). To enroll in Texas Medicaid, an Opioid Treatment Provider (OTP) must be licensed by HHSC as a Narcotic Treatment Program provider or by the appropriate state board where services are rendered. OTPs must be enrolled in Medicare.

Outpatient Rehabilitation Facility (ORF). To enroll in Texas Medicaid, an ORF must be Medicare-certified. ORFs are public or private institutions primarily engaged in providing, under medical direction, diagnostic, therapeutic, and restorative services to outpatients, and are required to meet specified conditions of participation.

Personal Assistant Services/PCS. Providers that want to participate in the delivery of PCS must have one of the following HHSC licensures:

- Personal assistance services (PAS)
- Licensed home health services (LHHS)
- Licensed and certified home health services (LCHHS)

Licensed Home and Community Support Services Agencies (HCSSA) that are not Medicare certified may provide ONLY Personal Care Services (PCS) under Texas Medicaid CCP.

Physiological Lab. To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

Portable X-Ray. To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. A physician must direct both radiological and physiological laboratories.

Radiation Treatment Center. To enroll in Texas Medicaid, Radiation Treatment Centers must be Medicare-certified and certified by HHSC Bureau of Radiation Control.

Radiological Lab. To enroll in Texas Medicaid, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. A physician must direct both radiological and physiological laboratories.

Renal Dialysis Facility. To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state that it is located to provide services. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

Rural Health Clinic – Hospital, Freestanding. Medicare is required for enrollment as a Title XIX Rural Health Clinic (RHC).

Skilled Nursing Facility. To enroll in Texas Medicaid, the provider must be licensed as a nursing facility by HHSC or by the appropriate state board where services are rendered. The provider must be actively enrolled in Medicare as a skilled nursing facility.

SHARS – School, Co-op, or School-Based Health Center. To enroll in Texas Medicaid, school-based health centers, including charter schools, must employ, or contract with, individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid State Plan for SHARS in order to bill and be reimbursed for program services. (See the current *Texas Medicaid Provider Procedures Manual*, School Health and Related Services.)

Specialized/Custom Wheeled Mobility. A provider supplying items of durable medical equipment that are powered or manual mobility systems, including seated positioning components, powered or manual seating options, electronic drive control, specialty driving controls, multiple adjustment frame, nonstandard optimizations, and other complex or specialized components for clients.

State Supported Living Centers (SSLC). SSLCs are public facilities that provide intermediate care to people with intellectual and developmental disabilities who live on an SSLC campus and outpatient acute care services to people who do not live on the SSLC campus. SSLCs must be approved by HHSC and must submit a copy of that approval with this application.

TB Clinic. To enroll in Texas Medicaid, the tuberculosis (TB) clinic must be approved by the DSHS Infectious Disease Control Unit Tuberculosis Program (IDCU/TB). The TB clinic must be one of the following: a public entity operating under an HHSC tax identification number (TB regional clinic), a public entity operating under a non-HHSC tax identification number (city/county/local clinic), or a non-hospital-based entity for private providers and a provider of TB-related clinic services.

To receive a DSHS Tuberculosis and Refugee Health Services Branch Medicaid Provider Application, send a request to the following address: Tuberculosis Elimination Division, ATTN: Financial Services and Medicaid Unit, 1100 West 49th Street, Austin TX 78756-3199, or call **1-512-533-3000** for more information.

You must attach a copy of your approval letter from the state of Texas.

Vision Medical Supplier (VMS). To enroll in Texas Medicaid, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare (Palmetto) Providers.

Case Management Services

Blind Children's Vocational Discovery & Development Program. The Texas Commission for the Blind (TCB) is eligible to enroll as a Medicaid provider of case management for blind and visually impaired clients (BVIC) younger than age 16.

Early Childhood Intervention (ECI). To participate in Texas Medicaid, an ECI provider must comply with all applicable federal, state, local laws, and regulations about the services provided. Contractors must be certified by the Texas ECI program and must submit a copy of the current contract award from the Texas ECI program.

You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention.

Home and Community Based Service–Adult Mental Health (HCBS-AMH). To enroll in Texas Medicaid, a HCBS-AMH provider must be approved by DSHS. HCBS-AMH providers must enroll as a facility and are not required to enroll in Medicare.

HCBS-AMH providers must submit proof of approval and adhere to the appropriate rules, licensing and regulations of the state in which they operate.

Intellectual and Developmental Disability Case Management (IDD)–Local Intellectual and Developmental Disability Authority (LIDDA). To enroll in Texas Medicaid, LIDDA providers of IDD case management must contact the HHSC at **1-512-438-3011** for approval. LIDDA providers are eligible to become providers of IDD case management with the approval of HHSC.

You must attach a copy of your approval letter from the state of Texas.

Mental Health (MH) Case Management–Local Mental Health Authority (LMHA).
To enroll in Texas Medicaid, LMHA providers must contact DSHS at **1-512-206-5288** to be approved. LMHA providers are eligible to become providers of MH case management services with the approval of DSHS.

You must attach a copy of your approval letter from the state of Texas.

MH Rehabilitative Services–LMHA. To enroll in Texas Medicaid, MH Rehabilitative Services–LMHA providers must contact DSHS at **1-512-206-5288** to be approved. LMHA providers are eligible to become providers of MH rehabilitative services with the approval of DSHS.

You must attach a copy of your approval letter from the state of Texas.

MH Case Management/MH Rehabilitative Services–Non-LMHA. Non-LMHAs are private providers of both MH case management and MH rehabilitative services, but they are not LMHAs. They must comply with all applicable federal and local laws and all of the regulations that are related to the services they provide. After receiving approval for enrollment in Texas Medicaid, the Non-LMHA provider must be credentialed by a Texas Medicaid managed care organization (MCO) to provide services to Texas Medicaid clients.

Note: *Non-LMHA providers must register to use the DSHS Clinical Management for Behavioral Health Services (CMBHS) clinical record-keeping system before providing services to Texas Medicaid clients.*

Women, Infant, & Children (WIC) (Immunization Only). To be eligible as a qualified provider for presumptive eligibility determinations the following federal requirements must be met. The provider must be 1) an eligible Medicaid provider; 2) provide outpatient hospital services, rural health clinic services, or clinic services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician (includes family planning clinics); and 3) receive funds from or participate in the WIC program.

Youth Empowerment Services (YES) Waiver. To enroll in Texas Medicaid, YES Waiver providers must contact DSHS at YESWaiver@dshs.state.tx.us to be approved. Upon approval by DSHS potential providers must enroll as a Medicaid provider for YES Waiver.

You must attach a copy of your YES Waiver DSHS contract.

Comprehensive Care Program (CCP) Services

Financial Management Services Agency (FMSA). To enroll in Texas Medicaid, FMSA providers must submit their contract with HHSC as a Financial Management Services Agency provider.

Milk Donor. To enroll in Texas Medicaid, the provider must adhere to quality guidelines consistent with the Human Milk Bank Association of Northern America.

Pharmacy. Pharmacy providers are eligible to enroll in CCP. To be enrolled in CCP, the pharmacy must first be enrolled in the Texas Medicaid Vendor Drug Program (VDP).

Pharmacies enrolling as CCP-only providers do not require Medicare certification to enroll. Only taxonomy code 336000000X is available for selection during the enrollment process.

Prescribed Pediatric Extended Care Center. To enroll in the Texas Medicaid Program, a Prescribed Pediatric Extended Care Center (PPECC) provider must be licensed by HHSC. PPECC providers must enroll as a facility and are not required to enroll in Medicare.

PPECC providers must submit proof of their licensure and adhere to the appropriate rules, licensing and regulations of the state in which they operate.

Service Responsibility Option (SRO). To enroll in the Texas Title XIX Medicaid Program, Service Responsibility Option providers must complete the Texas Medicaid enrollment application. Providers of personal assistance services must submit their contract with HHSC as a Service Responsibility Option provider.

Texas Vaccines for Children Program (TVFC)

Check the appropriate boxes in response to the questions. Providers that provide routinely recommended vaccines to children who are 18 years of age and younger can apply to receive free vaccines from TVFC. The TVFC Provider Agreement is available in the forms section of the TVFC website at **www.dshs.texas.gov/immunize/tvfc/ProviderResources.shtm**.

Provider of Services Information

This section is for provider specialty and demographic information. Provide complete and correct information as required.

Healthy Texas Women (HTW)

Choose the appropriate statement. If you will be rendering services for HTW clients, you must complete and submit the Healthy Texas Women Certification form with this application. This form must be completed and submitted by providers that render women's health and family planning services to clients who participate in the Healthy Texas Women program. An original signature is required. This form cannot be faxed to TMHP. The form is located in Appendix A of this application.

Important: *Under Texas Human Resources Code, Section 32.024(c-1),* and relating program rules in the Texas Administrative Code*, the provider or the provider's affiliated organization is not qualified to participate in and is ineligible to bill for services provided through* the Healthy Texas Women program *if the provider or anyone in the provider's organization performs or promotes elective abortions, or is an affiliate of another entity that performs or promotes elective abortions.*

IRS W–9 Form

Provide complete and correct information as required.

Provider Information Form

Each Provider must complete the Provider Information Form before enrollment.

Important: *The physical address is where health care is rendered. In the Physical Address field, providers* ***must enter the physical address*** *where the services are rendered to clients; the accounting, corporate, or mailing address must not be entered in the physical address field. If a site visit is required and cannot be conducted because the physical address was not provided, the enrollment application will be denied.*

Electronic Funds Transfer (EFT) Notification

To enroll in the EFT program, complete the attached Electronic Funds Transfer (EFT) Notification. You must return a voided check or signed letter from your bank on bank letterhead with the notification to the TMHP address indicated on the form.

Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Note: *All individuals listed in Section III(a) must submit a PIF-2.*

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is "Yes," list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is "Yes," identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is "Yes," list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship

Please disclose any of familial relationships between principals and/or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

Principal Information Form (PIF-2)

A separate copy of the Principal Information Form (PIF-2) must be completed in full for each principal, subcontractor, and creditor of the Provider, before enrollment.

HHSC Medicaid Provider Agreement

Complete the required information at the beginning of the form, read the agreement information, and sign and date the agreement to indicate that you have read and agree with the terms of enrollment as required by HHSC.

Important: *The physical address is where health care is rendered. In the Physical Address field, providers **must enter the physical address** where the services are rendered to clients; the accounting, corporate, or mailing address must **not** be entered in the physical address field. If a site visit is required and cannot be conducted because the physical address was not provided, the enrollment application will be denied.*

Additional Forms

Appendix A

The following are instructions for the additional attachments available in Appendix A:

Corporate Board of Directors Resolution

This form is required if the enrolling provider is incorporated. This form must be notarized, and an original signature is required. This form **cannot** be faxed to TMHP.

Medicaid Audit Information Form

This form must be completed and submitted by facilities.

Healthy Texas Women Certification

Refer to the HTW instructions on page 13 for additional information.

Note: *The following forms must be obtained from other sources and submitted with your application as appropriate for the requested provider type:*

Franchise Tax Account Status

This certificate must be obtained from the Texas State Comptroller's Office website at **https://mycpa.cpa.state.tx.us/coa/Index.html.**

There is no charge for this request.

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 Page from the State Comptroller's Office.

Frequently Asked Questions

Q. How long does it take to process an enrollment application?

A. It takes up to 60 business days to process the enrollment application once TMHP has received all of the information that is necessary to process it. It may take longer in special circumstances.

Q. Can I submit a temporary license?

A. TMHP only accepts temporary licenses from physicians and physician assistants.

Q. Do I have to notify TMHP when I receive my full license or when I update my license?

A. Yes. Providers are also required to submit to TMHP, within 10 business days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification to continued participation in Texas Medicaid.

Q. Am I required to disclose a conviction regardless of how long ago it occurred, e.g., 20 years ago?

A. Yes. All convictions must be disclosed regardless of when the conviction occurred.

Q. I was told that my conviction was dismissed because I participated in a deferred adjudication or first offender program. Why am I required to disclose it in the application?

A. Per 42 CFR 1001.2 a deferred adjudication, and any other first offender program, is considered to be a conviction and therefore is required to be disclosed.

Q. Should I send my application by regular or certified mail, or should I send it through an express mail service?

A. Do not send certified mail to TMHP. You can send your application by regular mail, but TMHP recommends using an express service, like FedEx or UPS, so that you have a tracking number, a delivery receipt, and a guarantee of quick delivery. Send express mail to our physical address:

TMHP-Provider Enrollment
12357B Riata Trace Parkway
Austin, TX 78727

Q. How will I receive my new Texas Provider Identifier (TPI)?

A. Notification letters are printed the business day after an application is processed. Notifications are mailed to the physical address listed on the application. New providers will also receive a welcome packet that includes orientation information and other important documents.

Q. Does TMHP supply claim forms?

A. TMHP does not supply CMS-1500, Dental ADA, and UB-04 claim forms. You can buy the forms at any medical office supply store. You can submit claims online for free using TexMedConnect.

Q. Should I wait to submit claims until I receive a TPI?

A. No. Please refer to "Claims Filing and Filing Deadline Information" in this section for more information about claims filing deadlines.

Q. As a Medicaid provider, how long do I have to retain records about the services I render?

A. You must retain records for a minimum of five years from the date of service or until all audit questions, appeal hearings, investigations, and court cases have been resolved. Freestanding rural health clinics (RHCs) must retain records for six years. Hospital-based RHCs must retain records for 10 years. The records retention requirements do not affect any time limits for pursuing administrative, civil, or criminal claims.

Q. How do I update my address, phone number, and other information?

A. You can update the following information online through your provider portal account at **https://secure.tmhp.com/MyAccount/default.aspx**:

- Address, telephone numbers, and office hours
- Languages spoken
- Additional sites where services are provided
- Accepting new patients
- Additional services offered
- Client age or gender limitations
- Counties served
- Medicaid waiver programs

All other information must be updated using the Provider Information Change (PIC) Form. This form is available on the provider forms page of the TMHP website at **www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx**.

Q. How long is my enrollment active?

A. All providers are enrolled under a limited enrollment as regulated by 42 CFR §455.414, and Title 1 Texas Administrative Code (TAC) §352.5, and §352.9. Providers are required to revalidate their enrollment at least every 3 to 5 years.

Claims Filing and Filing Deadline Information

As a potential new provider to Texas Medicaid, you must abide by the applicable claims filing procedures and deadlines as outlined in the current Texas Medicaid Provider Procedures Manual while your Texas Medicaid Provider Enrollment Application is in review by TMHP and HHSC. This is particularly important if you render Medicaid services to clients before you receive your welcome letter with your assigned provider identifier.

There is no guarantee that your application will be approved for processing or that you will be assigned a Texas Provider Identifier (TPI). If you decide to provide services to a Medicaid client before your application has been approved, you do so with the understanding that, if your application is denied, Texas Medicaid will not pay the claims and that the law also prohibits you from billing the Medicaid client for the services that you provided.

If you render services to Medicaid clients before you receive your TPI, you must follow the claims filing procedures and meet the filing deadlines that are specified in the most current *Texas Medicaid Provider Procedures Manual*.

All claims for services rendered to Medicaid clients who do not have Medicare benefits are subject to a filing deadline from date of service of:

- 95 days of the date of service on the claim
- 365 days for OUT-OF-STATE providers or from the discharge date for inpatient claims

Providers who render services to a Medicaid client before they complete the enrollment process and receive a TPI must submit claims within the following deadlines:

- Newly enrolled providers:
  - TMHP must receive claims that were submitted by instate providers and providers located within 50 miles of the Texas state border within 95 days of the date on which the new provider identifier was issued.
  - TMHP must receive the claims within 365 days of the date of service (DOS) (i.e., the date on which the service was provided or performed).
- Newly enrolled clients:
  - TMHP must receive the claims within 95 days of the date on which the client's eligibility was added to the TMHP eligibility file (i.e., the "add date").

- TMHP must receive the claims within 365 days of the DOS for professional or outpatient claims or within 365 days of the discharge date for inpatient claims.

- Clients with retroactive eligibility:
  - TMHP must receive the claims within 95 days of the date on which the client's eligibility was added to the TMHP eligibility file (i.e., the "add date").
  - TMHP must receive the claims within 365 days of the DOS for professional or outpatient claims or within 365 days of the discharge date for inpatient claims.
- Clients with dual Medicare and Medicaid eligibility:
  - When the rendered service is a benefit of Medicare and Medicaid, the claim must be submitted to Medicare first. TMHP must receive the claim for Medicaid's portion of the payment within 95 days of the date of the Medicare disposition.
  - When a client is only eligible for Medicare Part B, the inpatient hospital claim is sent directly to TMHP. TMHP must receive the inpatient claim within 95 days of the date of discharge.

Note: *TMHP only processes one client per Medicare RA. For multiple clients, submit one copy per client.*

The Texas Administrative Code (TAC), Code of Federal Regulations, and HHSC established these deadlines.

Therefore, providers must submit all claims for services that have been provided to Medicaid clients to the following address within the 95-day filing deadline.

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal. Procedures for appealing denied or rejected claims are included on the Remittance and Status (R&S) report and in the claims filing section of the *Texas Medicaid Provider Procedures Manual*.

Limited ("Lock–In") Information

Clients are placed in the Limited Program if, on review by HHSC and the Office of Inspector General (OIG), their use of Medicaid services shows duplicative, excessive, contraindicated, or conflicting health care and/or drugs; or if the review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services. Clients qualifying for limited primary care provider status are required to choose a primary care provider. The provider can be a doctor, clinic, or nurse practitioner in the Medicaid program. If a limited candidate does not choose an appropriate care provider, one is chosen for the client by HHSC / OIG after obtaining an agreement from the provider. The provider is responsible for determining appropriate medical services and the frequency of such services. A referral by the primary care provider is required if the client is treated by other providers.

Change of Ownership

Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and HHSC, a change of ownership of a facility does not terminate Medicare eligibility. Therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements:

1. Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
2. Complete new Medicaid provider enrollment packet.
3. Provide TMHP with copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners).
4. Give a listing of ALL provider identifiers affected by the change of ownership.
5. Complete and submit the CHOW Questionnaire and Statement.

Written Communication

Enrollment Applications:

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

Claims:

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Telephone Communication

CCP Provider Customer Service.....1-800-846-7470

TMHP Contact Center 1-800-925-9126

TMHP EDI Help Desk.....1-888-863-3638