TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Medicaid
Enrollment Application

Performing Providers

V. II

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Note: *For help with completing any of the forms above, please refer to the Performing Provider Application Instructions document, which is available for download from the forms page of the TMHP website at www.tmhp.com.*

Contact Information

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.

Contact Name: *Last*	*First*	*Middle Initial*

Contact Telephone Number:	**Contact Fax** *(if applicable)*:

Email Address *(if applicable)*:

Address: *Number* *Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Medicare Enrollment Information

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.

Texas Medicaid Identification Form

Type of Enrollment:	☐ New enrollment (new provider, practice location, etc.)	☐ Re-enrollment	
Requesting Enrollment As:	Performing Provider	**NPI:**	
Additional Program Enrollment:	☐ CSHCN Services Program		

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:*

- 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:

- ☐ Anesthesiologist Assistant ★ ✪ ▲
- ☐ Audiologist ★ ✪ ▲
- ☐ Certified Nurse Midwife (CNM) ★ ▲ ▼
- ☐ Certified Registered Nurse Anesthetist (CRNA) ★ ▲
- ☐ Chiropractor ★ ▲
- ☐ Dentist/Doctor of Dentistry as a Limited Physician ★ ✪ ▲
- ☐ Family Planning Agency ✚ ▼
- ☐ Genetics ✚ ▲
- ☐ Licensed Marriage and Family Therapist (LMFT) ▲
- ☐ Licensed Professional Counselor (LPC) ▲
- ☐ Licensed Midwife ▲ ▼
- ☐ Nurse Practitioner/Clinical Nurse Specialist (NP/CNS) ★ ✪ ▲ ▼
- ☐ 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 ★ ▲
- ☐ Qualified Rehabilitation Professional (QRP) ▲
- ☐ Social Worker (LCSW) ★ ✪ ▲
- ☐ Speech-Language Pathologist (SLP) ★ ▲

CASE MANAGEMENT SERVICES:

- ☐ Case Management for Children and Pregnant Women ▲ ●

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.)*

Legend:

- ● Approval Letter/Contract required
- ✪ Eligible for Medicare waiver request (you must check a Medicare waiver request box on page 2)
- ▲ License/certification required
- ✲ Proof of fingerprinting required
- ★ Medicare number required
- ✚ Must designate if public provider
- ♦ Palmetto number required
- ▼ Healthy Texas Women (HTW) Certification required for reimbursement

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

Public/Private Entities (*required for all providers*)**:** ***Definition:*** *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.*	
Are you a private or public entity?	☐ Private ☐ Public
Family Planning Agencies Only:	**Are you licensed as a Physician Assistant (PA) or a nurse recognized as an Advanced Practice Registered Nurse (APRN)?** ☐ Yes ☐ No If "Yes," please list the appropriate Sub-Specialty in Provider Specialty/Taxonomy Information section below (Certified Nurse Midwife [CNM], Clinical Nurse Specialist [CNS], Nurse Practitioner [NP], or PA)

Provider Specialty/Taxonomy Information

Group TPI (*if enrolling as a performing provider into an existing group*)**:**		
Specialty:		
Sub-Specialty (*if applicable*)**:**		
Primary Taxonomy Code (*10-digit*)**:**		
Secondary Taxonomy Code* (*10-digit*)**:**		
Non-Texas-Enrolled Taxonomy Code**:**		
Audiologist Providers Only:	**Do you provide hearing services for children?**	☐ Yes ☐ No
	Will you be fitting and dispensing hearing aids?	☐ Yes ☐ No

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

** *Non-Texas-Enrolled Taxonomy Codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid.*

Provider Demographic Information

Existing TPIs (*if applicable*)**:**					
Do you want to be a limited provider? (*see instructions for definition of "limited provider"*)	☐ Yes ☐ No				
Last Name, First Name:			**Maiden Name** (*if applicable*)**:**		
List any other alias, name, or form of your name ever used:					
Title/Degree:		**Social Security Number:**		**DOB:**	
Group's Tax ID Number:					
Group's Legal Name According to the IRS:					
Communication Preference:	☐ Email ☐ Mail				
Provider Business Email (*required*)**:**					
Secondary Email Address (*optional*)**:**					

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Provider Website Address *(if applicable)*:			
Physical Address Where Health Care is Rendered* (*Number, Street, Suite No., City, State, ZIP*):			
Accounting Address (*Number, Street, Suite No., 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 "Other," please explain:			
Telephone No.:		**Physical Address FAX No.:**	
Accounting/Billing Address FAX No. (*optional*):			
Accepting New Clients:	☐ Yes ☐ No	**Gender Served:**	☐ Male ☐ Female ☐ All
Client Age Restrictions:			
Counties Served:			

Indicate your reason for applying to join the Texas State Health-Care Programs *(Select one)*:

- ☐ Access to an online application
- ☐ Adding a new location
- ☐ Adding performing provider to an existing group
- ☐ Electronic claims processing
- ☐ Improved administrative processes
- ☐ Incentive programs
- ☐ Learned about Texas State Health-Care Programs at a conference
- ☐ Learned about Texas State Health-Care Programs at a provider workshop
- ☐ Recruited by Texas State Health-Care Programs staff
- ☐ Recruited by TMHP Provider Relations representative
- ☐ Re-enrolling a provider under an existing provider identifier
- ☐ Reimbursement increases
- ☐ Timely reimbursement

* *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.)

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.

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.

Driver's License No.:		**Expiration Date:**		**State:**	
Gender:	☐ Male ☐ Female				
Medicare Provider No.:		**Medicare Certification Date:**			

Professional License / Certification / Accreditation:		
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*)

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:**
Federal Tax ID Number:	
Contact Person Name:	**Telephone Number:**

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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)*

1.	**Name:**	**Social Security Number:**	**Date of Birth** (*mm/dd/yyyy*)**:**
	Physical Address: 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: 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: 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: 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: 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. **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? **Have you ever had your professional healthcare license or certification revoked, suspended, or otherwise restricted, which includes all disciplinary and non-disciplinary actions?** **Have you ever voluntarily surrendered a professional healthcare license or certification in lieu of disciplinary action?** *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☐ No ☐ Yes ☐ No ☐ 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? **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?** **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 ☐ Yes ☐ No ☐ 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: (a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether: (1) There is a post-trial motion or an appeal pending, or (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed; (b) A Federal, State or local court has made a finding of guilt against an individual or entity; (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or (d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described 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? *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.

HHSC Medicaid Provider Agreement

Name of provider enrolling:	
Medicaid TPI: *(if applicable)*	**Medicare provider ID number:** *(if applicable)*

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.*

Number	Street	Suite	City	State	ZIP

Accounting/billing address: *(if applicable)*

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. 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** 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 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.*

1. Complete the following required forms if applicable to your provider type and entity type. ***All items marked are required.***

- [x] Texas Medicaid Identification Form
- [x] Texas Medicaid Provider Enrollment Application
- [x] HHSC Medicaid Provider Agreement
- [x] Provider Information Form
- [ ] Healthy Texas Women Certification
- [ ] Physician Relationship Agreement for Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs)

2. If applicable, complete and/or submit the following optional forms.

- [ ] Texas Vaccines for Children (TVFC) Program Provider Agreement
- [ ] For CSHCN Services Program enrollment:
  - CSHCN Services Program Identification Form
  - Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program
  - Required Information for Designation as a Team Member or Affiliated Provider of a CSHCN Services Program Comprehensive Cleft/Craniofacial Team (as applicable)
  - Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider (as applicable)

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.***

- [x] HHSC Medicaid Provider Agreement
- [ ] Texas Vaccines for Children (TVFC) Program Provider Agreement

4. Attach all required documents

- [ ] **Mammography Services Providers:** Attach a copy of the certification of your mammography systems from the Bureau of Radiation Control (BRC).
- [ ] **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.

☐ **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*).

5. Make a copy for your records.

Be sure to make a copy of all documents for your own records.

6. Mail your application and all other required documents.

Mail your application and all other required documents to the following address:

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

Appendix A: Additional Forms

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

- Physician Relationship Agreement for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers
- Healthy Texas Women Certification

Physician's Letter of Agreement

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.*

Provider type: (*choose one*):	**Date agreement is effective with the referring/ consulting/supervising physician:**
☐ Certified nurse midwife (CNM) ☐ Licensed midwife (LM)	
CNM or LM Name:	**CNM or LM License Number:**
Referring/Consulting/Supervising Physician Name:	**Referring/Consulting/Supervising Physician License:**

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

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

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: _____