TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Medicaid
Public Health Emergency Enrollment Application

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 *(required)*:	**Communication Preference:**
	☐ Email ☐ Mail

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

Medicare Enrollment Information

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

Note: *If you render services for clients who are eligible for Medicare, you must be enrolled in Medicare.*

Medicare Provider No.:		**Medicare Certification Date:**	

Medicare Billing Acknowledgement Statement

Required for all providers, not just those that are not Medicare enrolled.

☐ 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

Enrollment Information

Type of Enrollment:	☐ New enrollment (new provider, practice location, etc.)	☐ Re-enrollment		
Requesting Enrollment As:	☐ Individual	☐ Facility	☐ Group	☐ Performing Provider
NPI:				
Additional Program Enrollment:	☐ I do not wish to participate as a provider in the CSHCN Services Program.			

Note: *For group enrollment, single-specialty groups must choose a specialty from the services list below. Clinic/group practices must choose "Clinic/Group Practice" from the services list below.*

Provider Type Selection

Please check only the appropriate box to ensure proper enrollment. See the legend on page 6.

TRADITIONAL/CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) SERVICES PROGRAM SERVICES:

- ☐ Ambulance/Air Ambulance ★ ✚ ▲
- ☐ Ambulatory Surgical Center (ASC) ★ ✚ ▲ ▼
- ☐ Anesthesiologist Assistant ★ ✪ ▲ ▼
- ☐ Audiologist ★ ✪ ▲ ▼
- ☐ Birthing Center ▲ ▼
- ☐ Catheterization Lab ★
- ☐ Certified Nurse Midwife (CNM) ★ ▲ ▼
- ☐ Certified Registered Nurse Anesthetist (CRNA) ★ ▲ ▼
- ☐ Chemical Dependency Treatment Facility ▲ ▼
- ☐ Chiropractor ★ ▲
- ☐ Clinic/Group Practice ★ ✪ ▼
- ☐ Community Mental Health Center ★ ▼
- ☐ Comprehensive Health Center (CHC) ★
- ☐ Comprehensive Outpatient Rehabilitation
- ☐ Facility (CORF) ★
- ☐ Dentist/Doctor of Dentistry as a Limited Physician ★ ✪ ▲ ▼
- ☐ Durable Medical Equipment (DME) ♦ ✲ ▼
  - ☐ Augmentative Communicative Devices Supplier (CSHCN)
  - ☐ Custom Durable Medical Equipment (DME) Supplier (CSHCN)
  - ☐ Expendable Medical Supplies (CSHCN)
  - ☐ Medical Nutritional Products Supplier (CSHCN)
  - ☐ Non Custom Durable Medical Equipment (DME) Supplier (CSHCN)
  - ☐ Total Parenteral Nutrition (TPN) Services Supplier (CSHCN)
- ☐ Family Planning Agency ✚ ▼
- ☐ Federally Qualified Health Center (FQHC) ★ ▼
- ☐ Federally Qualified Look-alike (FQL) ▼
- ☐ Federally Qualified Satellite (FQS) ★ ▼
- ☐ Freestanding Psychiatric Facility ✚ ▲ ★
- ☐ Freestanding Rehabilitation Facility ★
- ☐ Genetics ✚ ▲
- ☐ HCSSA ▲
- ☐ Hearing Aid ▲ ✲
- ☐ Home Health ★ ▲ ✲
- ☐ Hospital — In-State ✚ ▲ ★ ▼
- ☐ Hospital Ambulatory Surgical Center (HASC) ✚ ▼
- ☐ Hospital — Military ✚ ▲ ★
- ☐ Hospital — Out-of-State ✚ ▲ ★ ▼
- ☐ Hyperalimentation ♦ ✲ ▼
- ☐ Independent Diagnostic Testing Facility (IDTF) ★ ✚
- ☐ Independent Lab (No Physician Involvement) ★ ✚
- ☐ Independent Lab (Physician Involvement) ★ ✚
- ☐ Licensed Marriage and Family Therapist (LMFT) ▲ ▼
- ☐ Licensed Professional Counselor (LPC) ▲ ▼
- ☐ Licensed Midwife ▲ ▼
- ☐ Maternity Service Clinic (MSC) ✚ ▼
- ☐ Nurse Practitioner/Clinical Nurse Specialist (NP/CNS) ★ ✪ ▲ ▼
- ☐ Occupational Therapist (OT) ★ ▲
- ☐ Opiod Treatment Provider ✲ ✪ ▼

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Texas Medicaid Identification Form

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- ☐ Optician ★
- ☐ Optometrist (OD) ★ ✪ ▲ ▼
- ☐ Orthotist ★ ✪ ▲
- ☐ Outpatient Rehabilitation Facility (ORF) ★
- ☐ Personal Assistant Services/PCS ▲
- ☐ Pharmacy Group ★ ▼
- ☐ Pharmacist ★ ▲ ▼
- ☐ Physical Therapist (PT) ★ ▲
- ☐ Physician (MD, DO) ★✪ ▲ ▼

  OB/GYN and Pediatricians not required to have a Medicare Number
- ☐ Physician Assistant ★✪ ▲ ▼
- ☐ Psychologist ★ ▲ ▼
- ☐ Physiological Lab ★
- ☐ Podiatrist ★ ▲ ▼
- ☐ Portable X-Ray ★
- ☐ Prosthetist ★ ✪ ▲
- ☐ Prosthetist - Orthotist *(choose if licensed as both)* ★ ✪ ▲
- ☐ Qualified Rehabilitation Professional (QRP)▲
- ☐ Radiation Treatment Center ★
- ☐ Radiological Lab ★
- ☐ Renal Dialysis Facility ★ ✚ ▲ ▼
- ☐ Respiratory Care Practitioner (CRCP) ▲
- ☐ Rural Health Clinic – Hospital, Freestanding ★ ✚ ▼
- ☐ Skilled Nursing Facility ★ ▲
- ☐ SHARS — School, Co-op, or School-Based Health Center ✚
- ☐ Social Worker (LCSW) ★ ✪ ▲ ▼
- ☐ Speech-Language Pathologist (SLP) ★ ▲
- ☐ Specialized/Custom Wheeled Mobility ✲
- ☐ TB Clinic ✚ ●
- ☐ Vision Medical Supplier (VMS) ◆

CSHCN SERVICES PROGRAM SERVICES:

(Medicaid enrollment is not required for these provider types)

- ☐ Hospice
- ☐ Medical Foods Supplier

CASE MANAGEMENT SERVICES:

- ☐ Blind Children's Vocational Discovery & Development Program ● ▼
- ☐ Case Management for Children and Pregnant Women ▲ ● ▼
- ☐ Early Childhood Intervention (ECI) ✚ ●
- ☐ Financial Management Services Agency (FMSA) ●
- ☐ Home and Community Based Service - Adult Mental Health (HCBS-AMH)
- ☐ Intellectual and Developmental Disability (IDD) Case Management–Local Intellectual and Developmental Disability Authority (LIDDA) ✚ ● ▼
- ☐ Mental Health (MH) Case Management–Local Health Authority (LMHA) ✚ ● ▼
- ☐ MH Rehabilitative Services–LMHA ✚ ● ▼
- ☐ MH Case Management/MH Rehabilitative Services–Non-LMHA ▼
- ☐ Service Responsibility Option (SRO) ●
- ☐ Women, Infants & Children (WIC) – Immunization Only ● ▼
- ☐ Youth Empowerment Services (YES) Waiver ✚ ●

COMPREHENSIVE CARE PROGRAM (CCP) SERVICES:

- ☐ Dietician ▲ ▼
- ☐ Licensed Vocational Nurse (LVN) ▲ ▼
- ☐ Milk Donor ▼
- ☐ Occupational Therapist (OT-CCP) ▲
- ☐ Pharmacy ● ▼
- ☐ Physical Therapist (PT-CCP) ▲
- ☐ Prescribed Pediatric Extended Care Center ♦ ▲
- ☐ Registered Nurse (RN) ▲ ▼
- ☐ Speech-Language Pathologist (SLP-CCP) ▲

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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 http://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 3)
- ▲ 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

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 and Hearing Aid 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, include Re-enrolling TPI*)**:**			
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:		**Federal/Employer Tax ID Number:**	
Legal Name According to the IRS (*as shown on your income tax return/IRS W9 form*)**:**			
Type of Entity (As shown on your income tax return/IRS W9 form)			
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Limited liability company (Enter the tax classification [C=C corporation, S=S corporation, P=partnership]): _____ ☐ Trust/estate			

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Provider of Services Information

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Provider Demographic Information

Telephone Number:		**Physical FAX Number:**	
Physical Address Where Health Care is Rendered* (*Number, Street, Suite No., City, State, ZIP*)**:**			
Accounting Address (*Number, Street, Suite No., City, State, ZIP*)**:**			
Accounting/Billing Address FAX No. (*optional*)**:**			

Provider Information Form

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*)**:**

Are you enrolled in any other State's Medicaid Program?	☐ Yes ☐ No
If "Yes," provide the name of the State, and any ID number, if applicable:	
Have you ever 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 a citizen of the United States?	☐ Yes ☐ No
If "No," provide the country of which you are a citizen:	

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Disclosure of Ownership

Identify entities and individuals with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity and/or individuals name and federal tax identification or social security number..

Owner 1 Name: _____

Address: _____

Federal Tax ID: _____

Percentage of Ownership: _____

Owner 2 Name: _____

Address: _____

Federal Tax ID: _____

Percentage of Ownership: _____

Owner 3 Name: _____

Address: _____

Federal Tax ID: _____

Percentage of Ownership: _____

Owner 4 Name: _____

Address: _____

Federal Tax ID: _____

Percentage of Ownership: _____

Owner 5 Name: _____

Address: _____

Federal Tax ID: _____

Percentage of Ownership: _____

Owners, Partners, Officers, Directors, and Principals

Identify persons who are sole proprietors or owners, partners, officers, directors, and principals. If you have multiple individuals to disclose, provide the information requested below for all applicable parties.

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

The following questions are applicable to each person, as defined above:

First and Last Name: _____

Social Security Number: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

Do you have the legal right to work in the United States? ☐ 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:

Disclosure of Relationship

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

Provider/Principal 1: _____

Has a Relationship as: _____

to Provider/Principal Name 2: _____

Agreement

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.

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. This Public Health Emergency Application process is valid only during dates of the current federally-approved public health emergency.

Signature: _____ Date: _____

Submit Application