

THE MARYLAND HEALTHY KIDS/EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM PROVIDER APPLICATION FOR CERTIFICATION & PARTICIPATION

Provider Name: Donald Duck, MD Full Name with MI Group Name: Ms. Daisy Duck's Family Practice Practice name and/or DBA
Primary Address: Small World Lane Include Suite Group# (MA number): 1234567 00 Required
City: Our Town State: MD Zip: 21200 County: Dreams County Required
Specialty: Family Medicine Ages Served: 0-99 Contact Person: Goofy Hound e.g, Site/office manager
Telephone: 555-555-1234 Practice phone# Fax: 555-222-5678 Practice Fax# provider@daisyduckfamilypractice.com
MCO Participation (specify each MCO): Aetna / PP:MPC / Wellpoint / Medstar / Other add all MCO's for practice!!

I. PROVIDER QUALIFICATIONS (Check all that apply):

- National Provider Identifier (NPI): 1234567890
- Currently participate in the Maryland Medical Assistance Program; provider number: 9876543 00
- Currently participate with one or more Medicaid MCOs; MCO number (if not MA #): not required
- License number(s): D 09888 Specify state(s): Maryland

Provider shall meet one of the following requirements: (specify)

- Be board-certified, (circle specialty) pediatrics, family practice, internal medicine;
- Be a licensed physician or osteopath, or certified nurse practitioner, or physician assistant delivering primary health care to children and adolescents;
- Be a local health department or free-standing clinic.

II. CONDITIONS FOR PARTICIPATION

All providers rendering preventive screening services to children must meet the following conditions, which are specified in the Maryland Healthy Kids/EPSDT Program regulations (COMAR 10.09.23) and Program policies:

- (1) Provide or ensure the provision of the full set of screening procedures as outlined in the Healthy Kids Schedule of Preventive Health Care and in a manner prescribed by the Department in the Healthy Kids Provider Manual;
- (2) Provide inter-periodic and full screening as deemed medically necessary;
- (3) Provide or arrange for: a) referrals for diagnosis, treatment, and follow-up services if the screening indicates a need for additional services; b) acute and tertiary care; c) long-term and rehabilitative care; and d) referrals for specialty mental health care when appropriate;
- (4) Inform the parent or guardian of the need for preventive health care visits at the time of enrollment or assignment, and schedule appointments to facilitate adherence to the periodicity schedule (Schedule of Preventive Health Care);
- (5) Agree to cooperate with state and local health department efforts to assure that children receive needed follow-up and treatment services. This requires referrals to the local health departments when appropriate to track children for missed appointments and delays with immunizations and treatments.
- (6) Maintain a physical location where the full array of EPSDT screening and preventive health services are delivered;
- (7) Maintain a patient record system that is sufficiently detailed and current to allow another provider who is unfamiliar with the patient to properly continue treatment in the absence of the primary care provider. Additionally, the record must sufficiently document the preventive screening components in accordance with the Healthy Kids Schedule of Preventive Health Care;

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- (8) Agree to on-site visits by the State program staff that will:
 - Verify provider qualifications
 - Assess the need for provider/staff training, technical assistance, or in-service training,
 - Determine if equipment necessary to perform required procedures is available, functioning, and being properly used,
 - Review/audit Medical Assistance recipient charts to determine if the program standards are being met, if quality and quantity of child health services delivered is sufficient, and if appropriate referral and treatment services are adequately provided;
- (9) Agree to participate in the Vaccines for Children (VFC) Program to assure that needed vaccines are readily available to the Medicaid enrollee according to the currently recommended Immunization Schedule, and
- (10) Agree to cooperate with Department efforts to provide timely access for all child health services including services for children with special needs and children in state supervised care.

PROVIDER AGREEMENT

I _____ (print name) agree to comply with requirement listed in Section II Conditions for Participation and understand I may be granted a provisional certification upon review of my application. I also understand that I may receive full certification status only after the completion of an on-site review.

Signature: _____ Date: _____

**Required;
Handwritten**

DEPARTMENT CERTIFICATION

This provider meets the provider qualification requirements and conditions for participation listed in Sections I and II.

Nurse Consultant Signature: _____ Full Certification granted on (date): _____

Return to EPSDT Program by:
Mail: MDH – Unit 79
Healthy Kids Program
Division of Children’s Service
201 W. Preston Street, Room 210 Baltimore, MD 21201

OR FAX: 410-333-5426

OR Scan/email to: Lesa.Watkins@maryland.gov