

**Provider Information** 

## Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

## **PT 07 Special Other Chronic Hospital - Psychiatric**

If you have questions, please contact the Provider Enrollment Helpline at 1-844-4MD-PROV (1-844-463-7768)

Monday – Friday from 9am – 5pm.

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (<a href="mailto:eprep.health.maryland.gov">eprep.health.maryland.gov</a>) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (<a href="mailto:eprep.health.maryland.gov">eprep.health.maryland.gov</a>) "Applications" tab, along with any additional documents requested within the addendum.

| NPI:   |
|--|
|  |
| Tax ID:  |
|  |
| MA Provider Number (if already enrolled in Maryland Medicaid): |
|  |

Please visit <a href="health.maryland.gov/ePREP">health.maryland.gov/ePREP</a> for more information about ePREP



## **Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION** Department of Health PT 07 Special Other Chronic Hospital - Psychiatric

If you have questions, please contact the Provider Enrollment Helpline at 1-844-4MD-PROV (1-844-463-7768) Monday - Friday from 9am - 5pm.

Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

| _  |     |    | _  |
|----|-----|----|----|
| 50 | cti | on | ٠. |
| ЭE | :LL | OH | ١. |

Please upload the following documents to  $\underline{\text{ePREP}}$  :

## Se

| 1.      | A copy of your JCAHO certification   |  |
|---------|--|--|
| 2.      | A copy of your NCPDP certification, if applicable  |  |
| ctio    |  |  |
| ease    | e respond to the question below and upload the document (if applicable) to <u>ePREP:</u>   |  |
| 1.      | Will you be rendering physical rehabilitation services?  |  |
|         | YES NO   |  |
|         | If yes, please include a copy of your CARF certification   |  |
| 2.      | Will you be rendering x-ray or other radiology services?   |  |
|         | YES NO   |  |
|         | • If yes, please include a copy of your Radiation Machine Facility Registration and Certification issued by the Maryland Department of the Environment or x-ray certification from the state in which you practice in yo upload. |  |
| *<br>Co | Please email MDH.BHenrollment@Maryland.gov upon approval of your enrollment to ensure the ost Settled rates are added.   |  |