STATE OF MARYLAND
DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 168

December 29, 2000

Nursing Home Administrators

FROM: Joseph M. Millstone, Executive Director JMM
Office of Health Services

NOTE: A BILLING PROCEDURE CHANGE IS INCLUDED IN THIS TRANSMITTAL

Enrollment of Medicaid Nursing Home Providers as Therapy Providers in Order to Bill for Medicare Deductibles and the 20 Percent Coinsurance

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Due to consolidated billing, nursing home providers must bill Medicare directly for all physical, occupational and speech therapy services rendered to Medicare recipients, including those who are also Medicaid eligible. Also, as of October 1, 1999, these costs incurred for Medicaid recipients have not been allowable on providers' cost reports. To date, there has not been a mechanism available for providers to be reimbursed by Medicaid for Medicare deductibles and coinsurance for dually eligible recipients.

Effective immediately, Medicaid nursing home providers may enroll with the Medicaid Program as therapy providers solely for the purpose of billing for Medicare deductibles and coinsurance. Nursing home providers should enroll as Provider Type 28 – Therapy Group Provider and list individual specialties for Physical Therapy, Occupational Therapy and Speech Therapy with an enrollment status of 37 = Mcare Xover Only. The enrollment application is enclosed.

Providers should bill on either the HCFA-1500 form or the UB-92 claim form (however you bill to the Medicare intermediary) with an attached Medicare EOMB. The 9-month billing time limitation will be waived back to October 1, 1999. Providers should submit all claims beyond the 9-month period as a group, with an attached identifying memorandum, to the attention of Charlotte Krueger, Claims Processing Division, Room SS-18. The deadline for submitting these "old" claims is June 30, 2001.

Any questions regarding this transmittal should be directed to the Nursing Home Section of the Division of Long Term Care Services at (410) 767-1444, or to the Division of Children's Services, which will process the provider applications, at (410) 767-1485.

JMM/seh
Enclosure

cc: Nursing Home Liaison Committee
Charlotte Krueger
Rose Ann Meinecke

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION FORM

INSTRUCTIONS

Please fill in the requested information as completely as possible. Most blocks appearing on the application are self explanatory, however, we have provided the following form definitions to help clarify what information is requested:

NOTE: PLEASE ATTACH A COPY OF ALL DOCUMENTS, WHOSE NUMBERS ARE REFERENCED.

1	New Enrollment/Change in Previous Application/Requested Enrollment Date	Check the appropriate block. If the request is to change existing data, then you must enter your Medicaid Provider Number in the block following the arrow. The enrollment begin date for an approved application is based on the date the application(s) was received in this office. If you have already rendered service and require billing capability prior to the date your application is received by this office, please indicate a Requested Enrollment Begin Date. BECAUSE OF THE NINE (9) MONTH BILLING LIMITATION for claims submitted to the Program, the Provider Enrollment Section will only back-date your application three (3) months prior to its receipt date. In order to prevent the rejection of claims by the Program due to enrollment reasons, enrollment should take place prior to rendering care to Maryland Medical Assistance recipients.
2	Name of Business/Provider Name/Other Contact Program	If you have a business, such as a pharmacy or medical supply, use this block to enter your company's name. All physicians and other individual practitioners should enter last name, first name, middle initial and professional title. All professional groups should enter the corporate group name. ADDITIONALLY, PLEASE IDENTIFY ANY OTHER OFFICE PERSON WHICH MAY SERVE AS YOUR POINT OF CONTACT FOR QUESTIONS AND INQUIRIES.
3	Practice Business Address	Enter the address of your practice location where you render services to recipients.
4	City/State/Zip Code	Enter the City, State and Zip Code of your practice location where you render services to recipients.
5	Referral Service Indicator	Enter "Y" for Yes if you wish to participate in the Referral Services Program.
6	Telephone Number	Enter the telephone number of your practice location where you render services to recipients.
7	County	Enter appropriate two digit code for the county of your business or professional address. A listing of the county codes is provided for your reference at the end of these instructions.
8	Out-State	All Maryland and contiguous state providers, who serve Maryland Medicaid recipients, enter "C". All District of Columbia providers, who serve Maryland Medicaid recipients, enter "D". All non-contiguous state providers, who serve Maryland Medicaid recipients, enter "N".
9	Provider Type	Enter the two digit code for the appropriate provider type from the listing provided at the end of the these instructions.
10	Federal Tax Number/Social Security Number	Enter the Federal Employer ID Number and/or the Social Security Number of the individual, group or business to whom the Medicaid reimbursements will be made.
11	License Number/License Date/License Expiration Date	Enter your Medical license number, beginning effective date and expiration date.
12	Pharmacy Permit Number	Enter your Pharmacy permit number, if applicable.
13	CLIA Number/Lab Permit Number	Independent Laboratories MUST enter the Clinical Laboratory Improvement Amendments Identification Number. Practitioners providing laboratory services on specimens originating in the State of Maryland MUST enter a Laboratory Permit Number. The CLIA certification and/or Lab Permit MUST be submitted with the application, if applicable.

14	NPI	Enter your National Provider Identifier Number.
15	DEA Number	Enter your Drug Enforcement Agency number. If you do not have a DEA number, this block should be left blank.
16	Type of Practice	Enter the appropriate two digit code for your type of practice. If this does not apply, leave the block blank. For your reference, a listing of the practice codes is provided at the end of these instructions.
17	Ownership Code	Enter the appropriate one digit code to indicate the nature of ownership of your practice or business. A listing of the applicable codes is provided at the end of these instructions for your reference. Complete and sign the enclosed form DHMH 4126-G.
18	HMO Type Category	If you are applying as an HMO, enter FR to indicate the type of contract as Full Risk with Abortion or SL to indicate the type of contract as Stop Loss without Abortion. Otherwise, leave this blank.
19	Primary Speciality Indicator	Enter a "P" to designate the primary speciality. If speciality codes are entered, then you must designate one speciality as the primary speciality.
20	Speciality Code	Physicians, Dentists and Pharmacies MUST enter the appropriate three digits code from the Speciality Code listing provided at the end of these instructions. Enter OTH if you have another speciality not listed. PLEASE SPECIFY.
21	Certification Date	Enter the date you were certified for your speciality in MMDDYY format.
22	Certification Number	Enter the number, up to six digits, that was provided to you when you were certified for the associated speciality.
23	Category of Service Code	FOR DHMH USE ONLY. PLEASE DO NOT FILL IN.
24	Group Membership Name, Provider Number, Begin Dates	If you are a MEMBER OF A GROUP PRACTICE, please enter the name, Maryland Medicaid provider number and membership effective date for the group. If you are a GROUP PRACTICE, please list the names of each professional practicing in your group and his/her Maryland Medicaid provider number and membership effective date.
25	Local Health Dept. Clinic Indicator	Enter "Y" for Yes if your group operates a Local Health Department Clinic.
26	Freestanding Clinic Indicator	Enter "Y" for Yes if your group operates a Freestanding Clinic.
27	Health Care Institution Affiliation	If your group is affiliated with a Health Care Institution, enter the name and address of the Health Care Institution.
28	Salaried Indicator	Enter "Y" for Yes if your group is salaried by the institution.
29	Medical School Affiliation	If your group is affiliated with a Medical School, enter the name and address of the Medical School.
30	Rendering Only Indicator	Enter "Y" for Yes if you want to enroll as a "Rendering Only" practitioner. If you enroll as "Rendering Only," payments will be made in the name of your group for the services you rendered.
31	Pay to Address	Enter the address which you wish your Medicaid checks mailed. If you leave these blocks blank, your checks will be mailed to the practice name and address entered on the first page of the application.
32	Correspondence Address	Enter the address which you wish all your Medicaid related correspondence mailed. If you leave these blocks blank, correspondence will be mailed to the practice name and address entered on the first page of the application.
33	Your Fiscal Year End	Please enter the date on which your fiscal year ends (MMDD).
34	# of Beds	Enter the number of beds applicable for each Bed service type.

35	Laboratory Classifications	FOR DHMH USE ONLY. PLEASE DO NOT FILL IN.
36	Medicare Information	If you are participating in Medicare, please list the fiscal intermediaries with whom you are enrolled (i.e. Blue Cross of Maryland, Traveler's Group Hospital Insurance TGHI, etc.) and enter the provider number each has assigned to you.
37	Electronic Claims Submission	Please indicate if you would like to submit your claims electronically.
38	Other Practice Location Information	Please enter other locations where you service Maryland Medical Assistance recipients. Include all group address you are currently practicing under, IF APPLICABLE. Enter the License Number and Expiration date for each of these locations. If out of state, attach a copy of a current license.
39	Authorization	Please sign and date the application.
40	Provider Agreement	Please read and sign the Provider Agreement for Participation in the Title XIX Program (Rendering only Practitioners are excluded)

01	Allegany	07	Cecil	13	Howard	19	Somerset	40	Washington, DC
02	Anne Arundel	08	Charles	14	Kent	20	Talbot	99	Other State
03	Baltimore County	09	Dorchester	15	Montgomery	21	Washington		
04	Calvert	10	Frederick	16	Prince George's	22	Wicomico		
05	Caroline	11	Garrett	17	Queen Annes	23	Worchester		
06	Carroll	12	Harford	18	St. Marys	30	Baltimore City		

PROVIDER TYPE CODES

Code	Provider Type
50	**ADAA Certified Addictions Outpatient Prog**
T1	Ambulance Services
39	Ambulatory Surgical Center
75	Assisting Living Services Provider
19	**Audiology Services Provider**
80	**Behavior Consultation Provider**
81	**Case Management**
82	
13	
30	Clinic, Abortion
31	Clinic, Children and Youth
32	Clinic, Drug Abuse (Methadone)
33	Clinic, Family Planning
34	Clinic, Federally Qualified Health Center
35	Clinic, Local Health Department
36	**Clinic, Maryland Qualified Health Centers**
37	**Clinic, Rural Health**
90	**DDA Services Provider**
14	**Dental**
84	**Diabetes Education**
60	**Diagnostic Services, Other**
61	Dialysis Facilities
85	Dietician/Nutritionists
62	DME/DMS
51	EPSDT Therapeutic Intervention
52	EPSDT Therapeutic Nursery
40	**Home and Community Based Services, Other**
41	**Home Health Agency**
71	**Hospice Provider**

Code	Provider Type
05	
06	**Hospital, Special Pediatric**
55	
56	**Intermediate Care Facility for the Mentally Retarded (ICF-MR)**
91	**Local Education Agencies/Local Lead Agencies**
42	**Medical Day Care, Adult**
43	**Medical Day Care Children**
27	
29	**Mental Hygiene Administration Service**
21	**Nurse Anesthetists (Indiv. or Group)**
22	**Nurse Midwife (Indiv. or Group)**
23	**Nurse Practitioner (Indiv. or Group)**
25	Nursing Agency (Private Duty)
57	Nursing Facility
44	Personal Care Aide
45	Personal Care Aide Agency

Code	Provider Type
15	
53	
	Senior Center Plus
94	Social Worker
	Tape Intermediary
	Therapy Group Provider (PT, OT, Speech)
	Vision Care
PR	
	Mental Health Clinic
	Certified Professional Counselor
	School Based Health Center
	Services to Medically Complex Patients in Nursing Facilities
	Halfway House (Subs Abuse)
	MCO

01	General Hospital	22	Pharmacy chain, 11 + stores		
		23	Pharmacy, hospital based	50	**HMO**
		24	Pharmacy, nursing home based	99	**Other**
		25	Pharmacy, tax supported		
		30	Individual Practice		
10	Nursing Home	31	Individual practice, I/P hospital only		
		32	Individual practice, Emerg. room only		
		33	Individual practice, O/P or clinic only		
20	Pharmacy, single store	35	Group Practice		
21	Pharmacy chain, 2-10 stores				

OWNERSHIP CODES

1	County-owned facility
2	State-owned facility
3	City-owned facility
4	Church-owned facility
5	Privately owned, for profit

6	Privately owned, non-profit
7	Public corporation
8	Other

SPECIALITY CODES

PHYSICIAN SPECIALITY CODES

026	Allergy
045	
046	
047	Clinical Pathology
004	Colon & Rectal Surgery
060	Dermatological Immunology/Diagnostic & Laboratory Immunology
058	Dermatology
059	
017	
055	: Radiology
043	
033	
029	
034	
028	
051	Neurology with Special Qualification in Child Neurology
044	Nuclear Medicine
020	

024	Pediatric Pulmonology
002	Pediatric Surgery
016	Pediatrics
048	Physical Medicine & Rehabilitation
011	Plastic Surgery
052	Psychiatry
049	Public Health & General Preventive Medicine
039	Pulmonary Disease
056	Radiation Oncology
054	Radiology
010	Reproductive Endocrinology
040	Rheumatology
001	Surgery
005	Thoracic Surgery
006	Urology

DENTAL SPECIALITY CODES

113	Dental - Other
123	Endodontics
131	General Dentistry
181	Oral Surgery
182	Orthodontics
187	Pedodontics
188	Periodontics

PHARMACY SPECIALITY CODES

147	Home IV Therapy
151	Hospital Outpatient Pharmacy
156	Institutional Pharmacy
168	Multi-Speciality Pharmacy
184	Other Pharmacy
202	Retail Chain Pharmacy
204	Retail Single Pharmacy

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION FORM

IMPORTANT: Please read the attached Provider Instructions (DHMH XXXX-A) before proceeding.

[1] **New Enrollment** ☐ **Requested Enrollment Begin Date**

Change in Previous Application ☐→ **Provider Number**

FOR DHMH USE ONLY	
MMIS-II Number	
Application Date	
Eligibility Date	

[2]**NAME OF BUSINESS**

OR

PROVIDER NAME

OTHER CONTACT PERSON (If available)

[3] **PRACTICE/BUSINESS ADDRESS**

[4] **CITY** **ST** **ZIP CODE**

Will you accept REFERRALS at this location? (Y/N)

[5]**TELEPHONE NUMBER** [7]**COUNTY** [8]**OUT-STATE** [9]**PROVIDER TYPE**

****Please refer to the INSTRUCTIONS for the appropriate codes.***

[10] **FEDERAL TAX NUMBER** **SOCIAL SECURITY NUMBER**

The above Federal Tax Number (if indicated) belongs to:

VERIFICATION INFORMATION

[11]**LICENSE NO.** **LICENSE DATE** **LICENSE EXPIRATION DATE** [12]**PHARMACY-PERMIT**

[13]CLIA NUMBER [13] LAB PERMIT [14]NPI [15] DEA NUMBER

NOTE: Please attach copies of all documents, whose numbers are listed. All Maryland Nurse and all Out-of-State providers must submit a copy of their current license verification along with this application. All Maryland practitioners are required to have a laboratory permit No. (Health General Article §17-202 and 17-205, Annotated Code of Maryland) and CLIA identification number (Clinical Laboratory Improvement Amendments of 1988 Public Law 100-578) to perform laboratory services. Out-of-State providers are required to provide only CLIA Identification Numbers. Copies of the document must be submitted with the application. Maryland also requires all providers that provide laboratory services for other than their own patients, to enroll as medical laboratory providers.

PRACTICE INFORMATION

[16]TYPE OF PRACTICE | [17]OWNERSHIP CODE | [18]HMO TYPE CATEGORY

Please refer to the INSTRUCTIONS for the appropriate codes.

SPECIALITY INFORMATION

[19] PRIM IND	* SPECIALITY CODE	* CERTIFICATION DATE	* CERTIFICATION NUMBER	PRIM IND	SPECIALITY CODE	CERTIFICATION DATE	CERTIFICAITON NUMBER

Please refer to the INSTRUCTIONS for the appropriate codes.

Pursuant to amendments to Physicians Services Regulations (COMAR 10.09.02), effective July 1, 1979, the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the following criteria: (Please check the appropriate statement)

___ I have been declared board certified by a member of the American Board of Medical Specialist and currently retain that status. A photocopy of my speciality board certificate is attached.

___ I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate Residency review Committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited, and the completion date of my residency.

___ I have been declared board certified by a speciality board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my speciality board certificate is attached.

___ I have been declared board eligible by a speciality board approved by the Advisory Board of Osteopathic Specialists. Verification from my speciality board that I am board eligible is attached.

___ I have completed a residency program in a foreign country; my qualifications and training are acceptable for admission in to the examination system of the appropriate American Speciality Board. A letter of my speciality board verifying this is attached.

To be considered a Specialist, the letter or photocopy must be attached. If your application is for a group or professional association, each physician in the group or association who wishes to be considered a Specialist must submit the required verification.

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CATEGORIES OF SERVICE

[23] CAT OF SVC CODE	CAT OF SVC CODE	CAT OF SVC CODE	CAT OF SVC CODE	CAT OF SVC CODE	CAT OF SVC CODE	CAT OF SVC CODE

GROUP MEMBERSHIP INFORMATION

[24]NAME	PROVIDER NUMBER	BEGIN DATE

[25]Is your Group operating a Local Health Department Clinic? (Y/N)

[26]Is your group operating a Freestanding Clinic? (Y/N)

[27]If your group is affiliated with a Health Care Institution, please give its name and address:

___

[28]Is your group salaried by the institution? ___(Y/N)

[29]If your group is affiliated with a medical school, please give its name and address:

___

[30]Do you want to enroll as a "Rendering Only" practitioner? ____ (Y/N)

NOTE: All practitioners in a group must be enrolled as Medical Care Program providers.

ALTERNATIVE ADDRESS INFORMATION

[31]PAY TO ADDRESS

CITY ST ZIP-CODE -

[32]CORRESPONDENCE ADDRESS

CITY ST ZIP-CODE -

INSTITUTIONAL INFORMATION

[33]YOUR FISCAL YEAR END DATE:

BED DATA

SERVICE TYPE	[34]# OF BEDS
Intermediate Care (ICF)	
Acute Inpatient (INP)	
Skilled Nursing (SNF)	

SERVICE TYPE	# OF BEDS
Other (OTH)	
Chronic Hospital (CHB)	
Mental Retardation (MR)	

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LABORATORY CLASSIFICATIONS

[35]BEGIN DATE	[35]END DATE	[35]CODE	BEGIN DATE	END DATE	CODE

[36] MEDICARE INFORMATION

NAME	MEDICARE NUMBER

NOTE: Dialysis facility providers must attach a copy of the letter(s) from your intermediary showing all current composite rates.

[37] ELECTRONIC CLAIMS SUBMISSION

If you would like information concerning electronic claims submissions, please contact the System Operator at 410-767-5863.

[38] OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you service Maryland Medical Assistance recipients. Include all group addresses you are currently practicing under, IF APPLICABLE.

ADDRESS

CITY ST ZIP CODE -

PHONE: - - Will you accept REFERRALS at this location? (Y/N)

LICENSE NUMBER LICENSE EXPIRATION DATE

ADDRESS

CITY ST ZIP CODE -

PHONE: - - Will you accept REFERRALS at this location? (Y/N)

LICENSE NUMBER LICENSE EXPIRATION DATE

ADDRESS

CITY ST ZIP CODE -

PHONE: - - Will you accept REFERRALS at this location? (Y/N)

LICENSE NUMBER LICENSE EXPIRATION DATE

ADDRESS

CITY ST ZIP CODE -

PHONE: - - Will you accept REFERRALS at this location? (Y/N)

LICENSE NUMBER LICENSE EXPIRATION DATE

ADDRESS

CITY ST ZIP CODE -

PHONE: - - Will you accept REFERRALS at this location? (Y/N)

LICENSE NUMBER LICENSE EXPIRATION DATE

AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

AUTHORIZED PRACTITIONER'S, ADMINISTRATOR'S OR AUTHORIZED PROFESSIONAL RESPONSIBLE FOR QUALITY CARE.
(Please Print or Type)

DATE

SIGNATURE OF PRACTITIONER, ADMINISTRATOR OR AUTHORIZED PROFESSIONAL RESPONSIBLE FOR QUALITY OF PATIENT CARE

SIGNATURE OF OWNER (in the care of a Pharmacy)

Please return your completed application to

Programs Systems and Operations Administration
Provider Master Files
P.O. Box 17030
Baltimore, MD 21203

PROVIDER AGREEMENT
FOR PARTICIPATION IN THE TITLE XIX PROGRAM

This agreement is entered into between the Maryland State Department of Health and Mental Hygiene ("the Department") and ______________________________ ("the Provider) by ______________________________, the Provider's duly authorized representative (in the case of a group, institutional, or corporate provider), to provide covered services to Medicaid-eligible individuals in accordance with applicable federal and State law. It is understood that as used in the body of this agreement, the pronoun "He" is intended to include all pronouns and genders and is not to be construed as limiting in any way.

1 THE PROVIDER AGREES:

A. To comply with all of the applicable requirements of the Maryland Medical Assistance Program ("Program") as well as any other applicable regulations, transmittals and guidelines issued by the Department. The provider acknowledges his responsibility to become familiar with those requirements. The provider is advised that the applicable regulations may differ significantly from those of other third-party payer programs.

B. To maintain adequate records which fully describe the nature and extent of all goods and services provided and rendered, including but not limited to, charts, laboratory test results, medication records, and appointment books for a minimum of six (6) years and to provide them upon request to the Department and/or its designee. This requirement shall not be construed nor is it intended to limit or proscribe the nature and extent of records required to be maintained by the provider by any other laws, regulations, or agreements with third parties.

1 <u>Original</u> records must be made available upon request during onsite visits by Department personnel.

2 <u>Copies</u> of records are to be forwarded upon written request of the Department.

C. To protect the confidentiality of all recipient information, including names, addresses, medical services provided and medical data about the recipient, such as diagnoses and past history of disease and disability. Such information may be released to a third party other than another treating provider only upon the consent of the recipient or the Department, except as otherwise permitted by State or federal law or regulation, or other legal process.

D. To provide services without regard to race, creed, color, age, sex, national origin, marital status, or physical or mental handicap.

E. To not knowingly employ, or contract with a person, partnership, or corporation which has been disqualified from the Program to provide or supply services to Medical Assistance recipients unless prior written approval has been received from the Department.

F. To accept as payment in full the amount paid by the Program for the service rendered and not seek additional payment from the recipient. If the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or was not preauthorized if required by regulation, the provider agrees not to seek payment for that service from the recipient.

G. That if the recipient has insurance or other coverage or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for services covered by the Program, to seek payment from that source first. If payment is made by both the Program and the insurance or other source, the provider shall refund to the Department, within 60 days of receipt, the amount paid by the Program or the insurance or other source, whichever is less.

H. To accept responsibility for the accuracy of all claims submitted to the Program or which have been submitted to the Program on his behalf using the provider number issued in his name.

To attest that all claims submitted under his provider number shall be for medically necessary services, actually provided as described in the claim. The provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including expulsion from the Program, under relevant law or regulation.

That if the provider is a physician, he will, upon request, submit to the Program the name and applicable licensure for each physician extender in his employ and for whom the provider will submit claims or has submitted claims for services rendered to recipients. The physician is responsible for knowing and complying with the applicable regulations of the Program defining who is eligible to act as a physician extender under the Program, and to provide supervision as required by

the Program.

K. That in the case of a group provider, the individual provider rendering the service shall include on the claim his own provider number as well as the group provider number.

L. To furnish the Department, within 35 days of the Department's request, full and complete information about:

1 The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2. Any significant business transaction between the provider and any wholly-owned supplier, or between the provider and any subcontractor, during the 5 year period ending on the date of the request.

3. Any ownership interest exceeding 5% held by the provider in any other Medical Assistance provider.

M. That, upon request, and before the Department enters into or renews a provider agreement, the provider agrees to disclose the identity of any person who:

1 Has an ownership or control interest in the provider, or is an agent or managing employee of the provider; and

2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs.

II THE DEPARTMENT AGREES

A. To pay the provider for medically necessary services provided to recipients and covered by the Maryland Medical Assistance Program in accordance with all Program regulations and fee schedules as incorporated by reference in the Code of Maryland Regulations.

B To provide notice of changes in Program regulations through publication in the Maryland Register in accordance with its publication schedule.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this agreement by giving thirty (30) days notice in writing to the other party. The Provider shall notify recipients, before rendering additional services, that he no longer honors Medical Assistance cards.

B. That the effective date of this agreement shall be ______________________. DHMH will determine the effective date based on verification of the information contained in the provider application. This agreement shall remain in effect until such time as it is terminated by either party pursuant to the terms of this agreement. Termination of this agreement shall not discharge the obligations of the Provider with respect to services or items furnished prior to termination, including retention of records and restitution of overpayments.

C. That no employee of the State of Maryland or any department, commission, agency or branch thereof, whose duties as such employee include matters relating to or affecting the subject matter of this contract shall, while such employee, become or be an employee of the party or parties hereby contracting with said State of Maryland or any department, commission, agency or branch thereof without the written permission of the Department; and

D. That this agreement shall not be transferrable or assignable.

______________________________ Provider Signature Date	______________________________ 2/[illegible] Department Authorization Date
______________________________ Provider Name (Typed or Printed)	______________________________ 2/21/97 Assistant Attorney General Date
______________________________ Provider Address (Typed or Printed)	
______________________________ Provider Number	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION FORM

GROUP ADDENDUM

If your group is affiliated with a Health Care Institution, please enter the name and full address of the institution and a brief explanation of the group's duties:

NAME OF INSTITUTION:______________________________

ADDRESS:______________________________

____

DUTIES:______________________________

____

____

Is your group salaried by the above institution? Yes ___ No ___

Please indicate the terms of your contractual agreement with the above institution. For which services is your group salaried? (Please Circle the appropriate response)

PATIENT CARE TEACHING (FACULTY) ADMINISTRATION RESEARCH

CONSULTATIONS NOT APPLICABLE

If your group is affiliated with a medical school, please enter the name and full address of the institution and a brief description of the group's duties:

NAME OF INSTITUTION:______________________________

ADDRESS:______________________________

____

DUTIES:______________________________

____

____

If you are an M.D. of D.O., will you be dispensing pharmaceuticals other than samples (as a pharmacy)?
Yes___ No ___

If you are an O.D., are you practicing optometry exclusively? Yes ___ No ___or optometry as well as preparing and dispensing eyeglasses (as an optician)? Yes ___ No ___

LABORATORY INFORMATION - Completion of this section is required to be eligible for reimbursement of laboratory services provided. Failure to properly complete this section will result in the inability to be reimbursed for laboratory services.

Does your group provide medical laboratory services for other than the patients of the group?
Yes___ No ___ If yes, then the group MUST enroll as a medical laboratory provider.

STATE OF MARYLAND
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PROVIDER APPLICATION FORM

PRACTITIONER ADDENDUM

If you are participating in a group practice, do you also provide care to Maryland recipients in your private practice and wish to be reimbursed directly by the State (your personal tax identification number must appear on this application)? Yes____ No ___

If you are salaried as a staff M.D., D.O., D.D.S. or D.M.D., please enter the name and full address of the facility, your title and a brief explanation of your duties:

NAME OF FACILITY:______________________________

ADDRESS:______________________________

____

TITLE:____________________ DUTIES: ______________________________

____

____

If you are salaried as a staff M.D., D.O., D.D.S., or D.M.D., are you salaried for patient care? Yes ___No ___

If you are salaried as an instructor in a medical school, give the name and address of the school, your title, and a brief description of your duties:

NAME OF SCHOOL:______________________________

ADDRESS:______________________________

____

TITLE:____________________ DUTIES: ______________________________

____

____

If you are an M.D. of D.O., will you be dispensing pharmaceuticals other than samples (as a pharmacy)? Yes___ No ___

If you are an O.D., are you practicing optometry exclusively? Yes ___ No ___or optometry as well as preparing and dispensing eveglasses (as an optician)? Yes ___ No ___

LABORATORY INFORMATION - Completion of this section is required to be eligible for reimbursement of laboratory services provided. Failure to properly complete this section will result in the inability to be reimbursed for laboratory services.

Do you provide medical laboratory services for other than your own patients?
Yes___ No ___If yes, you MUST enroll as a medical laboratory provider.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION FORM

INSTITUTION ADDENDUM

DIALYSIS FACILITIES

Medicare Provider Number ______________________(attach a copy of letter with assigned number)

Attach a copy of the letter(s) from your intermediary showing all current composite rates.

NOTE: You will be paid ONLY for the rate(s) appearing in this/these letter(s) in addition to those services provided, but not included in the composite rate.

Portable X-Ray and other Diagnostic Services MUST supply the following:

Maryland Medical Test Unit Permit No. ________________________________(attach copy)

Do you intend to bill for portability? Yes ___ No ___

NOTE: All portable x-ray and other diagnostic services providers located within Maryland or serving patients located within Maryland MUST have a Maryland Test Unit Permit. The only out-of-state portable x-ray and other diagnostic services providers that do not have to have a Maryland Medical Test Unit Permit are those that serve Maryland Medicaid recipients in the State in which the provider is located and they must provide a Medicare Provider number.

PLEASE COMPLETE FORM DHMH 4126-G PROVIDER OWNERSHIP AND DISCLOSURE FORM AND SUBMIT WITH PROVIDER APPLICATION.

State of Maryland ✦ Department of Health and Mental Hygiene
Medical Assistance Program

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

____

Name of your Medical Service or Supply Provider Ownership (as contained on your application)

(Applicable to all Provider of items or services [1] except for individual practitioners or groups of practitioners [2])

Pursuant to 42 CFR §455.100 et. seq., the disclosure of the following is a required portion of the Maryland Medical Assistance Provider Application. Therefore, please answer the following questions and sign this document affirming that this information is true and complete, and return with your application.

A. Name any person who, with respect to the Title XIX Provider [3]:

1. is an officer or director ____

2. is a partner ____

3. has a direct or indirect ownership interest [4] of 5% or more ____

has a combination of direct and indirect ownership interests equal to 5% or more in the Provider

____

5. is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider ____

B. With respect to any subcontractor in which the Title XIX Provider has, directly or indirectly, an ownership or control interest of 5% or more, name any person who falls within A. 1-5 above, as applied to the subcontractor and specify which of the above categories he falls within ____

C If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship. ____

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling. ____

D. Name any person who has been convicted[5] of a criminal offense related to his involvement with any program operated under Title XVIII, XIX, or XX of the Social Security Act, and who, with regard to the Title XIX Provider, falls within the provisions of A.1-5, above, or is an agent or a managing employee [an individual, including a general manager, administrator and director, who exercises operational or managerial control or who directly or indirectly conducts the day-to-day operations] ________________________________

____

____

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health, Education and Welfare, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

A. the ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months business transactions in an aggregate amount in excess of $25,000.00 and

B. any significant business transactions[6], occurring during the 5-year period ending on the date of such request, between the Provider and any wholly-owned supplier[7] or any subcontractor.

____________________	____________________
DATE	AUTHORIZED SIGNATURE
	____________________
	POSITION

"Provider" or "provider" of services means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners

"Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

Identify any persons named, who are related to others named, as spouse, parent, child or sibling

"Ownership interest" means the possession of equity in the capital of, of stock in, or of any interest in the profits of the disclosing entity

"Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

"Determination of ownership or control percentage"

1) Indirect ownership interest - The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity A's interest equates to an 80 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest - In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets, equates to 4 percent and need not be reported

"Convicted" means that a judgement of conviction has been entered by a Federal, State, or local court, irrespective of whether an appeal from that judgement is pending

6 "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expense of a provider

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of a hospital bed, or a pharmaceutical firm)