



VIRGINIA MEDICAID PROVIDER ENROLLMENT & CHANGE FORM
Practitioner Billing and Servicing Providers

All *asterisked sections must be completed.

*Request Type

[] New Enrollment Request (not currently enrolled)

[] Re-Enrollment Request (previously enrolled)

Requesting Enrollment as [] Atypical [] Individual [] Individual Within a Group [] Ordering, Prescribing, or Referring

Effective Date of Enrollment: _____

1. *Provider/Applicant Information

Enrolling as *: [] Individual [] Business

Provider Name*. The Provider Name must be the current name on tax, corporation, or other legal documents.

Title: _____ Last Name: _____ First Name: _____

M.I. _____ Suffix: _____ or

Business Name _____

Provider Type*: _____ (If you are unsure, please refer to appendix)

Gender: Female [] Male []

Ethnicity: Hispanic/Latino [] Not Hispanic/Latino []

DOB* (mm/dd/yyyy): _____

Individual providers provide a Social Security Number. If the provider has both an EIN and SSN, they must provide both and supply a W9 as proof of the EIN.

SSN*: _____

FEIN*: _____

NPI: _____ If no NPI, please leave blank

Medicare Enrolled? [] Yes [] No If Yes, Medicare number: _____

Are you currently enrolled as a Provider*: [] Yes [] No

If Yes, Current Provider Service Location Number: _____

Were you previously enrolled as a Provider: [] Yes [] No If Yes, Previous Provider Identifier: _____

This provider enrollment application is for the Department of Medical Assistance Services of Virginia program(s). If your enrollment includes a request to participate in one or more of the Virginia Medicaid Managed Care Organizations or to provide Dental Services, your enrollment application and supporting documentation will be forwarded to those selected organizations. Please select from the program options below:

I will accept patients in the following programs: [] FFS only [] MCO(s) only [] FFS and MCO

Please select the programs to which you are applying. You must choose at least one if you checked an MCO box.

CCC Plus

- CCC Plus – Aetna Better Health of VA []
CCC Plus – HealthKeepers, Inc. []
CCC Plus – Molina Complete Care []
CCC Plus – Optima Health Community Care []
CCC Plus – UnitedHealthcare Community Plan []
CCC Plus – Virginia Premier Health Plan, Inc. []

Medallion 4.0

Med 4 – Aetna Better Health
Med 4 – Molina Complete Care
Med 4 – UnitedHealthcare Community Plan of VA

Med 4 – HealthKeepers, Inc.
Med 4 – Optima Health Plan
Med 4 – Virginia Premier Health Plan, Inc.

Others

Are you registered with CAQH? Yes No If yes, CAQH Provider ID: _____

Contact Information:

Title: _____ Last Name: _____ First Name: _____ M.I. _____

Address Line 1: _____ Address Line 2: _____

Country: _____ State: _____ City: _____

Zip Code/Postal Code: _____

Phone Type: _____ Phone Number: _____ Ext: _____

Email: _____

Preferred Method Communication:

Email Mail

2. *Specialties (Please write additional Specialties and Taxonomy(s) as needed

Primary Specialty: _____ Effective Date: _____ Taxonomy: _____

Specialty: _____ Effective Date: _____ Taxonomy: _____

Specialty: _____ Effective Date: _____ Taxonomy: _____

Additional Taxonomies:

Specialty: _____ Taxonomy(s): _____

Specialty: _____ Taxonomy(s): _____

Specialty: _____ Taxonomy(s): _____

3. *Provider Addresses & Accommodations

Provide the physical address where health care services are rendered.

Primary Service Location:

Service Location Name: _____

Contact Information:

Last Name: _____ First Name: _____ M.I. _____

Address Line 1: _____ Address Line 2: _____

Country: _____ State: _____ City: _____

County: _____ Zip Code: _____

Email: _____

Phone Type: _____ Phone Number: _____ Ext: _____

Hours of Operation: _____ (example: M-F 8-5 Sat 8-12, or Everyday 24 hours)

Is the Service location ADA compliant? ? Yes No

Is the service location accessible by public transportation? Yes No

What is your after-hour arrangement? _____

Phone Type: _____ Emergency Phone Number: _____ Ext: _____

Accepting New Patients with Special Needs

Accepting Existing Patients

Accepting New Patients

Accepting Family Members

Opt. Out of Provider Directory

Preferred Patient Gender Female only

Male only

No Restrictions

Patient Age Limits All Ages Newborn Age range only _____ (Youngest) _____ (Oldest)

(Age range of patients that you will see;
not the age range of your current patients).

4. *Addresses

***Pay to Address**

Same as Service Location (check if Pay to Address same as Service Location)

Location Name: _____

Last Name: _____ First Name: _____ M.I. _____

Billing Agent Name: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Email: _____

Phone Type: _____ Phone Number: _____ Ext.: _____

***Remit to Address**
(Remittance Advice)

Same as Service Location Same as Pay to (check if Remit to Address is same as Pay to or Service Location)

Location Name: _____
Last Name: _____ First Name: _____ M.I. _____
Billing Agent Name: _____
Address Line 1: _____ Address Line 2: _____
City: _____ State: _____ Country: _____ Zip Code: _____
Email: _____
Phone Type: _____ Phone Number: _____ Ext.: _____

***Mail to Address**
(Correspondence & Newsletters)

Same as Service Location Same as Pay to (check if Mail to Address is same as Pay to or Service Location)

Location Name: _____
Last Name: _____ First Name: _____ M.I. _____
Address Line 1: _____ Address Line 2: _____
City: _____ State: _____ Country: _____ Zip Code: _____
Email: _____
Phone Type: _____ Phone Number: _____ Ext.: _____
Preferred Communication Mail Email

Doing Business As Address

Same as Service Location Same as Pay to Same as Mail to (check if DBA Address is same as Pay or Mail to)

Location Name: _____
Last Name: _____ First Name: _____ M.I. _____
Address Line 1: _____ Address Line 2: _____
City: _____ State: _____ Country: _____ Zip Code: _____
Email: _____
Phone Type: _____ Phone Number: _____ Ext.: _____

5. *Organization Details

If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.

If your business is operated by a management company or leased (in whole or part) by another organization, information about the management company or organization must be included in the disclosure information.

Organization Type

- Limited Liability Company (LLC) For Profit Corp. Trust/Estate
- Corporation Partnership Individual
- Municipality Sole Proprietor
- CSB Government Owned Government Owned

Tax Classification

- Corporation For Profit Corp. Trust/Estate
- Government-Owned Municipality Sole Proprietor
- Partnership LLC

Entities doing business in the State, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Commonwealth of Virginia State Corporation Commission (SCC). For more information on the registration process, please go to the Secretary of State website at <https://www.scc.virginia.gov/clk/>

- Registered with Secretary of State Business Start Date: _____
- Incorporated Incorporation Date: _____
- Chain Affiliated
- Operated by Management Company
- Domestic Owned Corporation
- Foreign Owned Corporation

6. *Credentials (list all current licenses held; attach additional sheets as needed)

Add additional pages as needed.

Degree: _____ School: _____

Year of Graduation: _____

Degree: _____ School: _____

Year of Graduation: _____

License #: _____ State Issued: _____ Issuing Board: _____

Effective Date: _____ End Date: _____

License #: _____ State Issued: _____ Issuing Board: _____

Effective Date: _____ End Date: _____

License #: _____ State Issued: _____ Issuing Board: _____

Effective Date: _____ End Date: _____

Are you enrolled in other state Medicaid programs? Yes No If Yes, what states: _____

7. Provider CLIA Information (Complete if Applicable for Provider Type)

CLIA

CLIA Number: _____ Effective Date: _____ End Date: _____

CLIA Type:

Regular Waiver Accreditation Partial Accredited

Registration Cert Update Test Provider – Performed Microscopy Procedure (PPMP)

8. *Other

Languages:

Languages Accommodated: English Other (specify all): _____

Certifications:

Exempt from Accreditation

Specialty: _____ (number or description if not known)

Certificate Type: _____

Other Certification: _____

Effective Date: _____ End Date: _____

Please enter the provider website address below. It must begin with "HTTP:" or "HTTPS:" Followed by a valid address.

Provider Website URL : _____

Electronic Claims Submission Participation (applicable for individual enrollment only):

I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS. Yes No

If you answer No to the above, please provide documentation supporting your exemption request.

Claim Signature Waiver

I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer-generated, or stamped signature.

Yes No

9. EFT – Applicable to Individual Enrollment Type Only

Do you wish to enroll for Electronic Funds Transfer? Yes No

If No, an EFT Waiver attachment will be required.

Provider Contact Information

Title: _____ Last Name: _____ First Name: _____ M.I.: _____

Phone Number: _____ Ext.: _____ Fax Number: _____

Email: _____

Provider Agent Information

Provider Agent Name: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Title: _____ Last Name: _____ First Name: _____ M.I.: _____

Phone Number: _____ Ext.: _____ Fax Number: _____

Email: _____

Federal Agency Information

Program Agency Name: _____

Program Agency Identifier: _____ Agency Location Code: _____

Retail Pharmacy Information

Pharmacy Name: _____ Chain Number: _____

Parent Organization ID: _____ Payment Center ID: _____

NCPDP Provider ID Number: _____ Medicaid Provider Number: _____

Financial Institution Information

Financial Institution Name: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Phone Number: _____ Ext.: _____

Routing Number: _____ Type of Account: _____

Provider's Account Number: _____

10. Association to Group Practice(s)

*Individuals within a Group Association(s)
Add additional pages as needed.*

Group Provider Location ID: _____ NPI: _____
Title: _____ Last Name: _____ First Name: _____ M.I. _____
Suffix: _____

Provider Location ID: _____ NPI: _____
Title: _____ Last Name: _____ First Name: _____ M.I. _____
Suffix: _____

Provider Location ID: _____ NPI: _____
Title: _____ Last Name: _____ First Name: _____ M.I. _____
Suffix: _____

Provider Location ID: _____ NPI: _____
Title: _____ Last Name: _____ First Name: _____ M.I. _____
Suffix: _____

11. *Disclosures**Privacy Act Notice Statement**

This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer-identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used.

Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the State Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, State Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state, or logical agencies as appropriate.

Providing this information is mandatory to be eligible to enroll as a provider with the State Medical Assistance Program, under 42 CFR § 455 and CFR § 438. Failure to submit the requested information may result in a denial of enrollment as a provider, denial of continued enrollment as a provider, and deactivation of all provider numbers used by the provider to obtain reimbursement from the State Medical Assistance Program.

Ownership/Controlling Interest

Federal law requires individuals and entities with ownership, control, the management or a business relationship to submit a separate disclosure form for each entity or person affiliated with the provider. For more information on federal disclosure requirements, see 42 CFR § 455.100 – 106, 42 CFR § 455.436, 42 CFR § 1002.3, and CFR § 438.602 (b)

Disclosure Forms

Answer all questions. If you do not believe that a question is applicable, select a response of “No”. If you respond “Yes” to any question, please provide the additional information that may be requested.

New Provider Self Disclosure**Licensure**

1. Has any action ever been taken against your license or certification, by any state or certification board in the past 10 years?

Yes No

2. Have there been any changes to your license, or registration of certification in the past 10 years?

Yes No

Affiliations

3. Have you ever been terminated or not renewed your enrollment, or subject to any disciplinary action by any healthcare organization?

Yes No

Substance Registration

4. Has any action ever been taken against your federal or state-controlled substance certification or authorization?

Yes No

5. Has any action ever been taken against you during your participation in or have you been debarred from, any federal or state government healthcare program?

Yes No

Investigations

6. Have you ever been the subject of an investigation by any healthcare organization or military agency related to our performance of medical duties, for any action that qualifies as fraudulent activities?

Yes No

7. Are you aware of any information being reported regarding your performance as a medical practitioner, to any public medical malpractice reporting agency?

Yes No

8. Have you ever been under investigation by any state or federal regulatory agencies in the past 10 years?

Yes No

9. Have you ever been convicted, or are you currently under investigation, for sexual harassment or any other legal misconduct in the past 10 years?

Yes No

Sub-Contractor Disclosure

Sub-contractor disclosure form collects information on any subcontractor entity/individual with which the provider has had any business transactions totaling more than \$25,000 during the preceding 12 month period.

Provide the following information for each entity/individual as described above. Add additional sheets if needed.

Has the provider had business transactions with any subcontractor totaling more than \$25,000 during the preceding 12 month period?

Yes No

If Yes:

1. Is this entity an individual or a corporation?

Individual Corporation

Individual

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Effective Date: _____ End Date: _____

Corporation

Legal Name: _____ EIN: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Effective Date: _____ End Date: _____

Provide the following for all persons with an ownership or control interest in the subcontractor names above. Yes No

If Yes, the Owner

1. Is this entity an individual or a corporation?

Individual Corporation

Individual

% Interest: _____

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Effective Date: _____ End Date: _____

Corporation

% Interest: _____

Legal Name: _____ EIN: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Ownership and Control Interest

A person with an ownership or control interest means a person or corporation that has a direct or indirect ownership interest totally 5% or more in the provider, is an office or director of a provider organized as a corporation or non-profit, or is a partner in a provider organized as a partnership.

Providers are required to complete one form for each owner or controlling interest.

Is there any entity (individual or corporation) with an ownership or controlling interest in the disclosing entity as described above?

Yes No

If Yes:

1. Is this entity an individual or a corporation?

Individual Corporation

Individual

% Interest: _____

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Email Address: _____

Effective Date: _____ End Date: _____

Corporation

Legal Name: _____ EIN: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Email Address: _____

Effective Date: _____ End Date: _____

2. Does this entity have an ownership or controlling interest of 5% or more in any other provider, fiscal agent, or managed care entity?

Yes No

If Yes

% Interest: _____ Other Provider: _____ Tax ID: _____

3. Has this entity been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX service since the inception of these programs?

Yes No

If Yes

Offense Description: _____

Conviction Date: _____ Jurisdiction: _____

4. Has this entity ever had its billing privileges revoked or had its participation in the program terminated for cause?

Yes No

If Yes

Program: _____ State: _____ Date of Revocation: _____

5. Does this entity have any outstanding debt with State Medicaid, other state agencies, other state's Medicaid programs, or Medicare?

Yes No

If Yes, provide the following information below and attach documentation of the arrangements made to repay the debt.

Program: _____ State: _____ Amount of debt: _____ Date: _____

6. Has this entity had any healthcare-related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program?

Yes No

If Yes

Program: _____ State: _____ Action Imposed: _____ Date: _____

7. Has this entity had any non-healthcare-related adverse legal actions?

Yes No

If Yes

Program: _____ State: _____ Action Imposed: _____ Date: _____

8. For group providers only – Do any members of your group have a relationship with this entity?

Yes No

If Yes, please identify them below. If you are not enrolling as a group, please respond No to this question.

Name: _____ Relationship: _____ DOB: _____ SSN: _____

9. If an Individual was selected with Question #1, is this entity related to any other person with ownership or control interest as a spouse, parent, child, or sibling?

Yes No

If yes, provide the information to whom the disclosing entity completing this form is related.

Name: _____ Relationship: _____ SSN: _____

Managing Employees

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a corporation such as president, vice-president, CEO, CFO, and board of directors.

Is there any managing employee(s) associated with the provider’s organization?

Yes No

If Yes:

1. Provide the following information on all managing employees of the provider. Add additional pages as needed.

What is the Relationship of this individual(s) to the Provider’s Organization?

Board Member Corporate Officer Managing Employee
 Partner Shareholder

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Email Address: _____

Effective Date: _____ End Date: _____

2. Has this person been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Children’s Health Insurance Program, or the Title XX services since the inception of these programs?

Yes No

If Yes

Offense Description: _____

Conviction Date: _____ Jurisdiction: _____

3. Has this person previously participated or currently participates as a provider in Virginia Medicaid or any other state's Medicaid program or Medicare?

Yes No

If Yes

Program: _____ State: _____

4. Has this person ever had their billing privileges revoked or had their participation in the program terminated for cause.

Program: _____ State: _____ Date of Revocation: _____

5. Does this person have any outstanding debt with Virginia Medicaid, other Virginia State Agencies, other state's Medicaid Program, or Medicare?

Yes No

If Yes, provide the following information below and attach documentation of the arrangements made to repay the debt.

Program: _____ State: _____ Amount of debt: _____ Date: _____

6. Does any family or a household member have any outstanding debt with any State or Federal agency or program?

Yes No

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

7. Has this person had any healthcare-related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program?

Yes No

If Yes

Program: _____ State: _____ Action Imposed: _____ Date: _____

8. Has this person had any non-healthcare-related adverse legal actions?

Yes No

If Yes

Program: _____ State: _____ Action Imposed: _____ Date: _____

9. Is this person related to any other person with ownership or control interest as a spouse, parent, child, or sibling?

Yes No

If yes, provide the information to whom the disclosing entity completing this form is related.

Name: _____ Relationship: _____ SSN: _____

Business Transaction

Business Transaction means any significant business transaction, the provider entity had with any wholly-owned supplier or with any subcontractor during the preceding five-year period.

Provide the following information for each transaction as described above. Attach additional pages as needed.

Has the provider entity had any significant business transaction with any wholly-owned supplier or with any subcontractor during the preceding five-year period?

Yes No

If Yes:

Is this entity an individual or a corporation?

Individual Corporation

Individual

Title: _____ Last Name: _____ First Name: _____

M.I.: _____ Suffix: _____

SSN: _____ Birth Date: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Effective Date: _____ End Date: _____

Description: _____

Corporation

Legal Name: _____ EIN: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____ Zip: _____

Effective Date: _____ End Date: _____

Description: _____

12. *Attachments

Your provider type and specialty may require additional information. Please visit <https://virginia.hppcloud.com/ProviderEnrollment/EnrollmentCreate> to generate a checklist enlisting the credentials and required documentation for your enrollment application by enrollment, program, and specialty.

14. Backdating Enrollment Start Date

For New or Reenrolling providers ONLY. If you wish to have your effective date backdated, up to a year from the date of receipt of a completed application, please indicate below the date requested and rationale. Backdates will only be approved if confirmation can be obtained that screening requirements are met, as of the requested effective date, under 42 CFR §§455.410 and §455.450. (Currently enrolled providers, please use the Enrollment backdate form.) Attachments accepted.

Effective Date Backdate: _____

Office Use Only PECOS Effective Date _____ End Date _____

Rationale: _____

15. *Contact Information

Please provide the name and contact information of the individual to contact in regards to this form.

Title: _____ **Last Name:** _____ **First Name:** _____

M.I.: _____ **Suffix:** _____

Address Line 1: _____ **Address Line 2:** _____

City: _____ **State:** _____ **Country:** _____ **Zip:** _____

Phone Type: _____ **Phone Number:** _____ **Ext.:** _____

Fax : _____ **Email:** _____

Preferred Communication: Phone Email

16. *Participation Agreement & Signature

The provider agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid, in accordance with the terms below.

1. The provider is authorized to practice under the laws of the state in which they are licensed and is not, as a matter of state or federal law, disqualified from participating in the Program.
2. Consistent with 45 CFR §80.3, services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in VMAP (The Rehabilitation Act of 1973 §504 [29 U.S.C. §794]).
3. The provider agrees to keep such records as VMAP or any managed care organization with which they have entered into a provider agreement (the "MCO"), as applicable, determine necessary. The provider will furnish VMAP or the MCO, as applicable, on request, any information regarding payments claimed for providing services under the Virginia State Plan for Medical Assistance under Titles IXX or XXI of the Social Security Act. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP or the MCO, as applicable, for the submission of claims.
5. Payment made by VMAP or the MCO, as applicable, constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP or the MCO, as applicable.
7. Payment by VMAP or the MCO, as applicable, at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials or the MCO, as applicable, result in disallowance of amounts previously paid to the provider by VMAP or the MCO, the provider will reimburse VMAP or the MCO upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures, including those relating to utilization management of VMAP or the MCO, as applicable, as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. The provider agrees to screen all officers, directors, employees and contractors initially and on a monthly basis against the Exclusion Lists defined in the Social Security Act §1128 [42 U.S.C. §1320a-7] to determine whether any of these individuals have been excluded from participating in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in §1128B(f) of the Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider must be required to immediately report to the Contractor any exclusion information discovered. The provider must be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Members.
11. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party, or pursuant to the termination policies of the MCO, as applicable. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.

12. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP or the MCO, as applicable, for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia, or in accordance with the policies of the MCO, as applicable. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
13. Consistent with 45 CFR Part 162 the provider must submit their NPI for administrative and billing purposes under HIPAA, including when enrolling with DMAS and when requesting payment for claims.
14. The provider agrees that DMAS may disclose the provider’s NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Assistance.
15. The provider agrees to comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and MCOs specified in 42 CFR §489.102 and §417.436(d) .
16. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. Any changes to the provider’s correspondence address or any other contact information must be immediately reported to DMAS’s provider enrollment unit. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement

By signing below, I certify, under penalty of perjury, that the information and statements on this application and any accompanying documents are accurate and true and that I understand and agree to the terms of the Participation Agreement.

Title: ____ Provider First Name: _____ Provider Last Name: _____ M.I.: ____ Suffix: ____

Authorized Signature: _____

Title of Authorized Signature: _____

17. * Portal Registration Details

First Name: _____ Last Name: _____

EIN (last 4 digits only): _____ Preferred Language: _____

Email Address: _____ Confirm Email: _____

Birth Date: _____ Mobile Phone Number: _____

If the enrollment application is not complete upon receipt by the Virginia Medicaid Provider Enrollment Services, it will be returned to the provider.

Return all completed forms to one of the following:

Provider Enrollment Services Secure Email	vamedicaidproviderenrollment@gainwelltechnologies.com
Toll-Free Fax	1-888-335-8476
Provider Enrollment Services Mail Address	Provider Enrollment Services PO Box 26803 Richmond, VA 26803