Virginia Department of Medical Assistance Services (DMAS) v1.2

VIRGINIA MEDICAID PROVIDER ENROLLMENT & CHANGE FORM

Billing and Servicing Providers

*All *asterisked sections must be completed.*

*Request Type

☐ **New Enrollment Request** *(not currently enrolled)*

Requesting Enrollment as: ☐ **Facility/Corporation** ☐ **Atypical** ☐ **Group**

☐ **Re-enrollment, Revalidation Provider Service Location Id:** _____

1. *Provider/Applicant Information

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

Provider/Group/Institution Name: _____

Legal Name: _____ ***Doing Business As Name:*** _____

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

Business entities (groups, facilities and institutions) are to provide an Employer Identification Number (EIN), also known as a Federal Employer Identification Number **FEIN:** _____

Medicare Enrolled? ☐ Yes ☐ No If Yes, **Medicare number:** _____

NPI:_____ *If no NPI, please leave blank*

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 application is for enrollment into the Department of Medical Assistance Services Fee-for-Service (FFS), Managed Care Organization (MCO), and Dental and Behavioral Health Programs.

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 – Molina Complete Care of VA ☐

CCC Plus – UnitedHealthcare Community Plan ☐

CCC Plus – HealthKeepers, Inc. ☐

CCC Plus – Optima Health Community Care ☐

CCC Plus – Virginia Premier Health Plan, Inc. ☐

Medallion 4.0

Med 4 – Aetna Better Health ☐
Med 4 – HealthKeepers, Inc. ☐
Med 4 – Molina Complete Care ☐
Med 4 – Optima Health Plan ☐
Med 4 – UnitedHealthcare Community Plan of VA ☐
Med 4 – Virginia Premier Health Plan, Inc. ☐

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

2. *Specialties

Primary Specialty:_____ **Effective Date:**_____ **Taxonomy**: _____

Specialty:_____ **Effective Date:**_____ **Taxonomy**: _____

Specialty:_____ **Effective Date:**_____ **Taxonomy**: _____

Additional Taxonomies:

Specialty:_____ **Taxonomy(s)**: _____

Specialty:_____ **Taxonomy(s)**: _____

3. *Provider Addresses & Accommodations

Provide the physical address where health care services are rendered.

Primary Service Location:

Location Name: _____

Contact Information:

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

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

City:_____ **State:**_____ **Country:** _____**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 are your after-hour arrangements? _____

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)*

4. *Addresses

***Pay to Address**

(Remittance Advice & Checks)

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** ☐

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** ☐

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** ☐

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***.**

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. Bed Information

Applicable to Hospitals and Nursing Facilities Add additional pages as needed.

Bed Information 1:

Bed Type:

Alcohol and Drug Beds ☐ **Emergency Room Beds** ☐ **General Beds** ☐

Hospice Beds ☐ **Medicaid Certified Beds** ☐ **Medicare Certified** ☐

Physical Rehabilitation Beds ☐ **Psychiatric Beds** ☐ **Respiratory Beds** ☐

Total Certified/Licensed ☐ **Residential Treatment** ☐ **Skilled Nursing** ☐

Intermediate Care Facility ☐ **Skilled Nursing and Intermediate Care** ☐ **Specialized Care** ☐

Intermediate Care Facility Developmental Disabled ☐

Number of Beds: _____ Effective Date:_____ End Date: _____

Bed Information 2:

Bed Type:

Alcohol and Drug Beds ☐ **Emergency Room Beds** ☐ **General Beds** ☐

Hospice Beds ☐ **Medicaid Certified Beds** ☐ **Medicare Certified** ☐

Physical Rehabilitation Beds ☐ **Psychiatric Beds** ☐ **Respiratory Beds** ☐

Total Certified/Licensed ☐ **Residential Treatment** ☐ **Skilled Nursing** ☐

Intermediate Care Facility ☐ **Skilled Nursing and Intermediate Care** ☐ **Specialized Care** ☐

Intermediate Care Facility Developmental Disabled ☐

Number of Beds: _____ Effective Date:_____ End Date: _____

8. *Other

Languages:

Languages Accommodated: **English** **Other (specify all):** _____

Certifications:

Exempt from Accreditation ☐

Specialty: _____ (number or description if not known) refer to appendix

Certificate Type: _____ (do we want the list since this is probably different based on SP)

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:

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 answered No 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

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. Associations

An individual within a Group Association(s)
Add additional pages as needed.

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** ☐

Liability

10. **Has any action ever been taken against your professional liability coverage based on your history of medical practice?**

    Yes ☐ **No** ☐

11. **Have you had an adverse professional liability action within the past 10 years?**

    Yes ☐ **No** ☐

General

12. **Is the provider part of a provider entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act?**

    Yes ☐ **No** ☐

13. **Is the Provider out of compliance with the requirement?**

    Yes ☐ **No** ☐

Provide the following information for the contact person for audit purposes.

Title: _____ Last Name: _____First Name: _____
M.I.:_____ Suffix: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____Zip: _____

Phone Type: _____ Phone Number: _____

Provide the address for the physical location of the records to be kept.

P.O. Boxes and drop boxes are not acceptable.

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____Zip: _____

Phone Type: _____ Phone Number: _____

Convictions of Criminal Offense

14. Has the provider been convicted of a criminal offense related to their involvement in any program under Medicare, Medicaid, or the Title XX series program since the inception of those programs?

Yes ☐ **No** ☐

If yes:

Offense Description: _____

Conviction Date: _____ Jurisdiction: _____

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

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: _____ Full Name of the Other Provider: _____
Tax ID Type: _____ Tax ID: _____

Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Country: _____Zip: _____

Effective Date: _____ End Date: _____

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 the entity with the ownership or controlling interest in the disclosing entity is an individual, is this individual 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/entity 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 entity 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 ☐

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

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. Background Check Details

The Affordable Care Act requires that providers with an ownership of 5% or more and are considered a high category of risk, submit fingerprint and background checks.

If you are assigned to the high-risk category, additional information may be required

13. *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. Application Fee

The Affordable Care Act requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial revalidations, and change of ownership, as required, and is assessed in full for each service location enrolled in State Medical Assistance Program.

Fee Update effective January 1, 2022,

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications and reactivations due to being terminated for any reason. The following providers are exempt from the application fee:

Individual providers or non-physician practitioners

Providers who are enrolled in Medicare

Providers who paid the application fee to either Medicare or another state Medicaid plan after March 25, 2011

The application fee for 2022 is **$631**.

Note: To waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required and must be dated after March 25, 2011. Proof of Payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee.

If an application is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the application will be pended and the application fee requested.

Please answer all questions. If you answer "NO" to all the questions below, then you must pay an application fee.

Application Fee Questions

Service Location – If the service location is enrolled in Medicare the fee payment is not required.

1. **Is the service location enrolled in Medicare?**

   Yes ☐ **No** ☐

Medicaid Program – If the service location has paid an application fee to another Medicaid program then the fee payment is not required.

2. **Have you paid an application fee to another state's Medicaid program for the service location?**

   Yes ☐ **No** ☐

Waiver Received – If you have received a waiver from the programs mentioned below a fee payment is not required.

3. **Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship?**

   Yes ☐ **No** ☐

Financial Hardship – If you are requesting a waiver for financial hardship, please submit a letter explaining the financial hardship along with your enrollment application, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

4. **Are you requesting a waiver of the application fee because of financial hardship?**

   Yes ☐ **No** ☐

15. 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.

Office Use Only
PECOS Effective Date_____End Date _____

Effective Date Backdate: _____

Rationale: _____

16. *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** ☐

17. *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 l973 §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