Montana Healthcare Programs Provider Enrollment Application

PROVIDER TYPE

*Please enter your provider type from the following list. _____

Ambulance	Hearing Aid Dispenser	Optician
Ambulatory Surgical Center	Home and Community-Based Services	Optometrist
Audiologist	Home Dialysis Attendant	Personal Care Agency
Birthing Center	Home Health Agency	Pharmacist
Board Certified Behavior Analyst	Home Infusion Therapy	Pharmacy
Case Management – Mental Health	Hospice	Physical Therapist
Case Management – Non-Mental Health	Hospital – Critical Access	Physician
Certified Nurse Specialist	Hospital – Inpatient	Physician Assistant
Chiropractor	Hospital – Swing Bed	Podiatrist
Clinic – Podiatry	Independent Diagnostic Testing Facility (IDTF)	Private Duty Nursing Agency
Clinic – Physical Therapy	Indian Health Services (IHS)	Program for All-Inclusive Care for the Elderly (PACE)
Clinic – Dental	Intermediate Care Facility – Mentally Retarded	Psychiatrist
Clinic – Physician	Laboratory	Psychologist
Clinic – Chemical Dependency	Licensed Addiction Counselor	Registered Nurse Anesthetist
Clinic – Freestanding Dialysis	Licensed Direct Entry Midwife	Residential Treatment Center
Clinic – Rural Health	Licensed Professional Counselor	Respiratory Therapy (EPSDT)
Clinic – FQHC	Mental Health Center	School
Clinic – Public Health	Mobile Imagining Service	Skilled Nursing Facility/ Intermediate Care Facility – Mental Aged
Clinic – Clinic/Group Not Otherwise Specified	Nurse Midwife	Social Worker
Dental	Nurse Practitioner	Speech Pathologist
Denturist	Nursing Home	Taxi
Durable Medical Equipment	Nutritionist / Dietician	Therapeutic Group Home
EPSDT	Occupational Therapist	Transportation – Non-emergency
Eyeglasses Contractor	Opioid Treatment Program	Tribal
Eyeglasses Contractor (CHIP)		

Targeted Case Management providers only. If you selected Targeted Case Management as your provider type, what type of services do you wish to provide?

_____ TCM Pregnant Women

_____ TCM Developmental Disability

_____ Children with Special Healthcare Needs

_____ TCM Mental Health

School-Based Services providers only. If you selected School-Based Services as your provider type, select the type of School-Based Services you are enrolling for.

_____ Individualized Education Plan (IEP) Services

_____ Comprehensive School and Community Treatment (CSCT) Team Services
If CSCT, indicate the team number you are enrolling.

TEAM _____

TAXONOMY CODES

Please enter up to three taxonomy codes.

_____ _____ _____

PROGRAM TO ENROLL IN

You may enroll as a Medicaid provider, CHIP provider, or both.

_____ Medicaid only
_____ Children's Health Insurance Program (CHIP) only (dental providers only)
_____ Both Medicaid and CHIP (dental providers only)

NATIONAL PROVIDER IDENTIFIER

Enter your 10-digit National Provider Identifier (NPI) number. _____

If you are a healthcare provider, this is required. If you are a healthcare provider and do not have an NPI, you must obtain one from https://nppes.cms.hhs.gov/#/ before you complete your enrollment.

If you are an atypical provider, you might not have an NPI. If not, check below and we will assign you a new provider number.

_____ I am an atypical provider, and I do not have an NPI.

INDIVIDUAL PROVIDER NAME

Full name is required for individual practitioner.

*Last Name _____ *First Name _____ MI _____

_____ Miss _____ Mrs. _____ Mr. _____ Ms.

Professional Title _____

*SSN _____ *DOB _____

ORGANIZATION NAME

If enrolling as an organization, indicate name.

*Organization Name _____ *EIN _____

PHYSICAL OR PRACTICE ADDRESS / CONTACT INFORMATION

*Address _____ (P.O. boxes are not acceptable.)
Address Line 2 _____ (P.O. boxes are not acceptable.)
*City _____ *State _____ *ZIP _____ - _____
County (only required for in-state providers) _____
*Telephone _____ Extension _____
Administrative Fax _____ Extension _____

LENGTH OF ENROLLMENT

If physical or practice address is in any state other than Montana, enter desired length of enrollment. Desired Enrollment Period (enrollment period will begin on the date of submission).

_____ 1 month
_____ 3 months
_____ 6 months
_____ Specific dates of service
_____ Indefinite

Specific Dates From _____ / _____ / _____ To _____ / _____ / _____

Note: The "to" date is only required if "Specific Dates of Service" is selected as the Desired Enrollment Period.

CORRESPONDENCE ADDRESS

*Do you want to direct your provider correspondence to an address other than the practice address or pay-to address?

_____ Yes _____ No

If yes, enter your correspondence address.

Address _____

Address Line 2 _____

City _____ State _____ ZIP _____ - _____

County (only required for in-state providers) _____

CONTACT E-MAIL ADDRESS

***Note:** You must enter at least one, and may add up to five, contact e-mail addresses.

*E-Mail Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

*E-Mail Address _____

E-Mail Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

E-Mail Address _____

E-Mail Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

E-Mail Address _____

MOST CURRENT PROFESSIONAL LICENSE INFORMATION

Up to five licenses can be added.

License Number ______________________________ State __________

Effective Date ______ / ______ / ______ Expiration Date ______ / ______ / ______ **Note:** An expiration date is only required for an out-of-state license.

Have you had any action or sanction against your license within this state? ______ Yes ______ No

If yes, indicate reason. If choosing Other, indicate reason.

- ☐ Revoked ☐ Suspended ☐ Inactive ☐ Fines Assessed
- ☐ Education Required ☐ Expired ☐ Terminated ☐ Other ____________________

License Number ______________________________ State __________

Effective Date ______ / ______ / ______ Expiration Date ______ / ______ / ______ **Note:** An expiration date is only required for an out-of-state license.

Have you had any action or sanction against your license within this state? ______ Yes ______ No

If yes, indicate reason. If choosing Other, indicate reason.

- ☐ Revoked ☐ Suspended ☐ Inactive ☐ Fines Assessed
- ☐ Education Required ☐ Expired ☐ Terminated ☐ Other ____________________

License Number ______________________________ State __________

Effective Date ______ / ______ / ______ Expiration Date ______ / ______ / ______ **Note:** An expiration date is only required for an out-of-state license.

Have you had any action or sanction against your license within this state? ______ Yes ______ No

If yes, indicate reason. If choosing Other, indicate reason.

- ☐ Revoked ☐ Suspended ☐ Inactive ☐ Fines Assessed
- ☐ Education Required ☐ Expired ☐ Terminated ☐ Other ____________________

License Number ______________________________ State __________

Effective Date ______ / ______ / ______ Expiration Date ______ / ______ / ______ **Note:** An expiration date is only required for an out-of-state license.

Have you had any action or sanction against your license within this state? ______ Yes ______ No

If yes, indicate reason. If choosing Other, indicate reason.

- ☐ Revoked ☐ Suspended ☐ Inactive ☐ Fines Assessed
- ☐ Education Required ☐ Expired ☐ Terminated ☐ Other ____________________

License Number ______________________________ State __________

Effective Date ______ / ______ / ______ Expiration Date ______ / ______ / ______ **Note:** An expiration date is only required for an out-of-state license.

Have you had any action or sanction against your license within this state? ______ Yes ______ No

If yes, indicate reason. If choosing Other, indicate reason.

- ☐ Revoked ☐ Suspended ☐ Inactive ☐ Fines Assessed
- ☐ Education Required ☐ Expired ☐ Terminated ☐ Other ____________________

BOARD CERTIFICATION

*Are you board certified? ______ Yes ______ No

If yes, what is your certification type?

______ State license

______ County/City license

______ Other

Certification Date ______ / ______ / ______ Certification Number ____________________

OWNERSHIP TYPE

*Enter your type of ownership.

_____ Individual
_____ Partnership
_____ Corporation
_____ Hospital-Based
_____ Group
_____ Clinic
_____ Other

PROVIDER-BASED FACILITIES

*Montana Medicaid only recognizes Provider-Based Facilities that have received official designation from the Centers for Medicare and Medicaid Services (CMS). Have you been designated by CMS as a "Provider-Based Facility"?

_____ Yes _____ No

If yes, include your CMS designation letter with your enrollment paperwork.

TAX REPORTING STATUS

*Tax Reporting Status _____ Individual _____ Organization

INDIVIDUAL FILING INFORMATION

Enter the name and Social Security number of the individual for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the **billing** provider on the claim.

Last Name _____ First Name _____ MI _____

Social Security Number _____

The U.S. Department of Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.

Gender _____ Male _____ Female

Race _____ Asian or Asian American or Pacific Islander
_____ Hispanic
_____ White (not Hispanic)
_____ Black (not Hispanic) or African-American
_____ North American Indian or Alaska native

BUSINESS FILING INFORMATION

Enter the name and Federal Employer Identification Number (FEIN) or Employer Identification Number (EIN) of the business for which this application is being filed. The name must match the name on file with the IRS exactly. This is the entity to which payments will be made when the enrolling provider is the **billing** provider on the claim.

Organization Name _____

FEIN/EIN _____

OWNERSHIP/CONTROL INFORMATION

This section must be completed for each person who has a direct or indirect ownership and/or controlling interest in the entity and/or provider specified in this enrollment application. This section must also be completed for each managing employee or agent of the enrolling entity and/or provider.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity (provider).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing provider entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity (provider).

A person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling 5% or more in a disclosing entity (provider); (b) has an indirect ownership interest equal to 5% or more in a disclosing entity (provider); (c) has a combination of direct and indirect ownership interests equal to 5% or more disclosing entity (provider); (d) owns an interest of 5% or more in any mortgage, deed of trust note or other obligation secured by the disclosing entity (provider) if that interest equals at least 5% of the value of the property or assets of the disclosing entity (provider); (e) is an officer or director of a disclosing entity (provider);that is organized as a corporation; or (f) is a partner in a disclosing entity (provider); that is organized as a partnership.

(a) *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 8 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.

(b) *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 interest owned in the obligation is multiplied by 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.

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 operation of an institution, organization, or agency.

An agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

OWNERSHIP/CONTROL INFORMATION, CONTINUED

At least one person must be added as owner, and up to 24 persons can be added. If you need additional fields, please download and print them at http://medicaidprovider.mt.gov/providerenrollment and attach additional pages to the paper enrollment package when they are completed.

*Ownership

_____ *Owner _____ Agent _____ Managing Employee _____ Subcontractor

*Last Name _____ *First Name _____ MI _____

*Date of Birth _____ *Social Security No. _____

*Country of Birth _____

State of Birth (Only required if country of birth is U.S.) _____

Physical Address

*Address _____

Address 2 _____

*City _____ *State _____ *ZIP _____ - _____

County _____ (Only required for in-state Business.)

Mailing Address (If different from the Physical Address.)

*Address _____

Address 2 _____

*City _____ *State _____ *ZIP _____ - _____

County _____ (Only required for in-state Business.)

*Telephone _____ Extension _____

Montana Provider Number (Enter the owner's or managing employee's most recent provider number, if applicable.)

_____

*Are you the spouse, parent, child, or sibling of a person with ownership or control interest?

_____ Yes _____ No Name _____

*Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program?

_____ Yes _____ No

If yes, enter explanation. _____

_____

OWNERSHIP ORGANIZATION INFORMATION

*Do you have ownership or control interest of 5 percent or more in another organization that participates in publicly funded healthcare programs?

_____ Yes _____ No

If yes, complete information below.

Note: Up to four organizations can be added. For any organization added, all information is required.

Legal Business Name _____ SSN/EIN _____

Physical Address _____

Physical Address 2 _____

City _____ State _____ ZIP _____ - _____

Legal Business Name SSN/EIN _____

Physical Address _____

Physical Address 2 _____

City _____ State _____ ZIP _____ - _____

Legal Business Name _____ SSN/EIN _____

Physical Address _____

Physical Address 2 _____

City _____ State _____ ZIP _____ - _____

Legal Business Name _____ SSN/EIN _____

Physical Address _____

Physical Address 2 _____

City _____ State _____ ZIP _____ - _____

SUBSIDIARY OR JOINT VENTURE BUSINESS INFORMATION

*Is your organization a subsidiary company or joint venture? ________ Yes ________ No
If yes, complete information below.

Note: Up to four organizations can be added. ***Required information**.

Legal Business Name ____________________ Employer ID ____________

Provider Number ____________________

Address ____________________

Address Line 2 ____________________

City ____________ State ________ ZIP ________ - ________

County (only required for in-state providers) ____________________

Telephone ____________ Extension ________

Administrative Fax ____________ Extension ________

Legal Business Name ____________________ Employer ID ____________

Provider Number ____________________

Address ____________________

Address Line 2 ____________________

City ____________ State ________ ZIP ________ - ________

County (only required for in-state providers) ____________________

Telephone ____________ Extension ________

Administrative Fax ____________ Extension ________

Legal Business Name ____________________ Employer ID ____________

Provider Number ____________________

Address ____________________

Address Line 2 ____________________

City ____________ State ________ ZIP ________ - ________

County (only required for in-state providers) ____________________

Telephone ____________ Extension ________

Administrative Fax ____________ Extension ________

Legal Business Name ____________________ Employer ID ____________

Provider Number ____________________

Address ____________________

Address Line 2 ____________________

City ____________ State ________ ZIP ________ - ________

County (only required for in-state providers) ____________________

Telephone ____________ Extension ________

Administrative Fax ____________ Extension ________

PREVIOUS PROVIDER NUMBER(S)

*Have you previously billed Montana Medicaid, Healthy Montana Kids (HMK)/CHIP, or MHSP?
_____ Yes ____ No

Note: In cases of reenrollment, it is critical that you provide accurate information so we may set up your new enrollment consistently with your previous enrollment. Up to four provider numbers can be added. Please enter all that apply to the enrolling provider type.

Provider # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Provider # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Provider # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Provider # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

PREVIOUS TAX ID

*Have you changed or ever used another Tax ID number? _____ Yes _____ No
Note: Up to four tax IDs can be entered.

Tax ID # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Tax ID # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Tax ID # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

Tax ID # _____

Begin Date _____ / _____ / _____ End Date _____ / _____ / _____

CLIENT DEMOGRAPHICS

Number of clients currently being seen (Montana Medicaid clients only) _____

Gender of clients _____ Male _____ Female _____ Both

EARLIEST DATE OF SERVICE

*Have you already provided services to a Montana Medicaid, Healthy Montana Kids (HMK)/CHIP, or MHSP client?
_____ Yes _____ No
If yes, earliest date of service _____ / _____ / _____

DEA NUMBER

If you have a Drug Enforcement Agency (DEA) number, enter it here. _____

LABORATORY INFORMATION

*Do you bill laboratory services? __________ Yes ________ No

If yes, enter CLIA Number. **Note:** Up to 10 CLIA types can be added.)

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date / / Expiration Date / /

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

Effective Date ________ / ________ / ________ Expiration Date ________ / ________ / ________

CLIA Number ________________________________

CLIA Type __________ Accreditation __________ Provider Performed Microscopy Procedures
__________ Compliance (Regular) __________ Registration
__________ Partial Accreditation __________ Waiver

FISCAL YEAR-END MONTH

_____ January	_____ May	_____ September
_____ February	_____ June	_____ October
_____ March	_____ July	_____ November
_____ April	_____ August	_____ December

MEDICARE

*Are you enrolled in the Medicare program? _____ Yes _____ No (If No, go to Payment and RA Information.)

Have you had site visits in accordance with your enrollment with Medicare or another state's Medicaid or CHIP program?

_____ Yes _____ No

If Yes, provide date for the site visit. Date _____ / _____ / _____

Have you paid the application fee to Medicare or another state's Medicaid or CHIP program?

_____ Yes _____ No

If Yes, indicate which program, state, and date.

☐ Healthy Montana Kids ☐ CHIP ☐ Medicaid ☐ Medicare

State _____ Date _____ / _____ / _____

Have you been revalidated by Medicare or another state? Yes _____ No _____

If Yes, indicate validation source, state, and date.

☐ Medicare ☐ Another State

State _____ Date _____ / _____ / _____

PAYMENT AND REMITTANCE ADVICE (RA) INFORMATION

Payments will be made via Electronic Funds Transfer (EFT) unless extenuating circumstances exist. If you feel you have extenuating circumstances that prohibit you from receiving payment via EFT, include a signed letter explaining why paper checks are required to request a waiver.

Please select your payment schedule and RA options. **Note:** Electronic Statement of Remittance (ESOR) is an electronic image of the remittance advice.

_____ Weekly EFT Payment with ESOR

*Do you wish to receive an electronic remittance advice in the HIPAA standard ANSI 835 transaction format?

_____ Yes _____ No

If yes, enter the Submitter ID of the entity you want your 835 delivered to. This is the Submitter ID of your clearinghouse, billing agent, or yourself if you conduct these transactions yourself.

Submitter ID _____

NCPDP (NABP) NUMBER (PHARMACY PROVIDERS ONLY)

Is this a pharmacy that has been recently purchased? _____ Yes _____ No

Date of Sale _____ / _____ / _____

Do you wish to keep the same NCPDP (NABP) number? _____ Yes _____ No

If yes, what is your NCPDP (NABP) number? _____

PASSPORT

Do you already have a Passport number? _____ Yes _____ No

If yes, enter your current Passport number. _____

CONTACT INFORMATION FOR ENROLLMENT

*Provide contact information in case there are questions regarding this enrollment application.

*Contact Name _____ *Telephone _____ Extension _____