72 HOUR PRESUMPTIVE ELIGIBILITY CRISIS STABILIZATION PROGRAM
PROVIDER ENROLLMENT ADDENDUM

NPI Provider Number: ______________________________

The individual or entity identified below has applied for enrollment and is enrolled as a provider in the Montana Medicaid Program ("Medicaid"), and has also requested enrollment as a provider under the 72 Hour Presumptive Eligibility Program established in ARM Title 37, Chapter 89 (the “Program”).

In consideration of enrollment in the Program and Program payments made to the Provider for covered medically necessary services under the Program, the Provider acknowledges and agrees to the following:

As a condition of participation in the Program, the Provider must be and remain enrolled as a Medicaid Provider. Participation in the Program shall be limited to the categories of services that are covered services under the Program and for which the Provider is enrolled in Medicaid.

The Provider agrees to comply with and be bound by all applicable laws, regulations, rules and written policies pertaining to the Program, and those Medicaid laws, regulations, rules and written policies applicable under the Program, including but not limited to the Montana Code Annotated, the Administrative Rules of Montana, written policies of the Department of Public Health and Human Services (DPHHS) and the Program Provider Handbook.

DPHHS is authorized to use the information contained in the Provider's Medicaid Provider Agreement for purposes of administering the Program. The Provider acknowledges and agrees that the provisions of the Medicaid Provider Agreement shall apply to the Program as if the Program services were Medicaid services, except that this Addendum shall not be construed to make applicable to the Program any provisions of State or Federal laws, regulations, rules and policies not otherwise applicable to the Program.

Enrollment in the Program under this Addendum shall be effective upon written notification to the Provider of enrollment in the program by DPHHS. This addendum shall terminate, without affecting the Provider's Medicaid Provider Agreement, upon 60 days written advance notice by DPHHS to the Provider, 60 days advance written notice by the Provider to DPHHS, or upon the termination of the Program.

This Addendum shall be a part of the Provider's Medicaid Provider Agreement for purposes of governing the Provider's participation in the Program. However, this Addendum shall not in any way reduce or modify the Provider's obligations under the Provider's Medicaid Provider Agreement with respect to participation or provision of services under the Montana Medicaid Program.

Individual Practitioner Name Printed	
Individual Practitioner Signature	Date
or for facilities and non-practitioner organizations:	
Authorized Representative Name Printed	Title/Position
Address	Telephone Number
Authorized Representative Signature	Date