Montana Healthcare Programs
Provider Enrollment

Thank you for choosing to enroll as a Montana Healthcare Programs Provider. All applicable sections of the provider enrollment form must be completed to process your application. The 4-digit ZIP code extension is required on all addresses. **Incomplete applications will not be processed.**

All forms that require a signature must have an original or valid digital signature. Stamped or copied signatures are not accepted. A photocopy may be sent for the W-9. Signed material may be mailed, faxed, or securely emailed. Your application will not be processed until both application and supplemental information are received.

Sign and return this application along with any additional required documents to:

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Or

Fax: (406) 442-4402 Attn: Enrollment
Email: MTEnrollment@conduent.com Subject: Enrollment

Passport to Health reenrollment is ***not*** required.

Rendering providers are required to be enrolled and their NPI must be indicated on the claim in the appropriate field. Individuals must only enroll one time, regardless of the number of locations in which they practice, with the exception of enrolling to provide waiver services. Participation in the waiver program requires separate enrollment for the separate provider type. Individuals who will not be identified as the Pay-To on a claim may want to consider enrolling as Rendering Only, or Ordering, Referring, Prescribing (ORP). Montana Healthcare Programs encourages a Group/Rendering setup, where the Group/Clinic as the Pay-To on a claim, and the individual servicing provider as Rendering/Treating.

If you have any questions regarding information required on the enrollment application, please contact Montana Provider Relations by calling (800) 624-3958 or (406) 442-1837 or sending an email to MTEnrollment@conduent.com

Applicants who wish to change information on a submitted application or change information for an existing provider must contact Montana Provider Relations directly and request changes in writing.

Montana Healthcare Programs
(Medicaid, HMK *Plus*/Children's Medicaid, HMK/CHIP)
Provider Enrollment Checklist

For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. The following information must be read, signed, and dated as applicable.

All Medicaid-Only Providers

_____ 1. Read, sign, and date the Montana Healthcare Programs Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign. It must be signed by all who are required to sign.

_____ 2. Complete, sign, and date the printed Disclosures, Screening and Enrollment Requirements.

_____ 3. Complete, sign, and date the printed W-9 form found at https://www.irs.gov/forms-pubs/irs-section-508-compliant-pdf-forms.

_____ 4. Complete, sign, and date the printed Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Authorization Agreement.

_____ 5. Include a **photocopy of your current professional license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also include a photocopy of your license covering that date of service.

_____ 6. Include a **photocopy of your applicable board certification**.

_____ 7. Complete the Trading Partner Agreement to enable access to the Montana Access to Health web portal.

_____ 8. Include a photocopy of the organization's W-9 if there is ownership or control interest of five percent or more in other organizations that bill for publicly funded healthcare programs.

_____ 9. If you perform laboratory services, you must enclose a **photocopy of the current CLIA certification** for each of the rendering providers or practice locations reported on this application.

_____ 10. Include your CMS Provider-Based Facility Designation (if applicable).

_____ 11. Check here if you have paid an application fee and/or enrolled in Medicare, Healthy Montana Kids (HMK) and/or another State's Medicaid or CHIP program. Provide your receipt from Medicare, HMK or another State's Medicaid or CHIP program.

_____ 12. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number. Changes for tax ID will only be made retroactive to the beginning of the current tax year.

Medicaid Pharmacy Providers Only

_____ 1. If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's NABP number, you must indicate an effective date after the termination date for the previous provider.

Medicaid and Montana HMK/CHIP Providers (Dental Only)

In addition to the above Medicaid-only requirements:

_____ 1. Read, sign, and date the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign.

HMK/CHIP Only Dental Providers
In addition to the above Medicaid-only requirements:

_____ 1. Read, sign, and date the HMK/CHIP Provider Enrollment Agreement and Signature Page. If the application is for an individual, the individual who will be providing the service must sign. If the application is for an organization, an individual authorized to enter the organization into a legal contract must sign.

You do not need to read, sign, and date the Montana Healthcare Programs Provider Enrollment Agreement and Signature Page if you are enrolling to provide **only** HMK/CHIP services.

School-Based Services Providers
In addition to the above Medicaid-only requirements:

_____ 1. If the school is enrolling for a CSCT provider number, the Comprehensive School and Community Treatment Contract must be read, signed, and dated by both the school and the mental health center the school is contracting with. The contract language included in this package is boilerplate and may be changed per the needs of the school and the mental health center. Please identify if replacing team or adding to existing team roster.

You will be notified in writing upon approval/denial of your enrollment request. Please contact Montana Provider Relations if you have not received a status after thirty (30) working days of receipt at our office. Do not bill Montana Healthcare Programs for any services until you have received, in writing, notice of your approval and its effective date. Claims submitted prior to completion of provider enrollment will be denied.

If you are re-enrolling due to a change in tax reporting, please supply a clear effective date of the change. The provider is responsible for adjusting any claims submitted and paid prior to approval of the new enrollment.

Disclosures, Screening and Enrollment Requirements

Title 42—Public Health
Part 455—Program Integrity: Medicaid
Subpart B—Disclosure of Information by Providers and Fiscal Agents
Source: 44 FR 41644, July 17, 1979, unless otherwise noted.

455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding—(a) Disclosure by providers and fiscal agents of ownership and control information; and (b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

455.101 Definitions.

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

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in §438.2.

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

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

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.

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

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

Prepaid ambulatory health plan (PAHP) has the meaning specified in §438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in §438.2.

Primary care case manager (PCCM) has the meaning specified in §438.2.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

Termination means—(1) For a—(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and (ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. (2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. (3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—(i) Fraud;(ii) Integrity; or (iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

[44 FR 41644, July 17, 1979, as amended at 51 FR 34788, Sept. 30, 1986; 76 FR 5967, Feb. 2, 2011]

455.102 Determination of ownership or control percentages.

(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.

455.103 State plan requirement.

A State plan must provide that the requirements of §§455.104 through 455.106 are met.

455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) *Who must provide disclosures*. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) *What disclosures must be provided*. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures: (1)(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. (ii) Date of birth and Social Security Number (in the case of an individual). (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest. (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse,

parent, child, or sibling. (3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest. (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) *When the disclosures must be provided*—(1) *Disclosures from providers or disclosing entities*. Disclosure from any provider or disclosing entity is due at any of the following times: (i) Upon the provider or disclosing entity submitting the provider application. (ii) Upon the provider or disclosing entity executing the provider agreement. (iii) Upon request of the Medicaid agency during the re-validation of enrollment process under §455.414. (iv) Within 35 days after any change in ownership of the disclosing entity. (2) *Disclosures from fiscal agents*. Disclosures from fiscal agents are due at any of the following times: (i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process. (ii) Upon the fiscal agent executing the contract with the State. (iii) Upon renewal or extension of the contract. (iv) Within 35 days after any change in ownership of the fiscal agent. (3) *Disclosures from managed care entities*. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times: (i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process. (ii) Upon the managed care entity executing the contract with the State. (iii) Upon renewal or extension of the contract. (iv) Within 35 days after any change in ownership of the managed care entity. (4) *Disclosures from PCCMs*. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section. (d) *To whom must the disclosures be provided*. All disclosures must be provided to the Medicaid agency. (e) *Consequences for failure to provide required disclosures*. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

455.105 Disclosure by providers: Information related to business transactions.

(a) *Provider agreements*. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) *Information that must be submitted*. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) *Denial of Federal financial participation (FFP)*. (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under §420.205 of this chapter (Medicare requirements for disclosure). (2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) *Information that must be disclosed*. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who: (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) *Notification to Inspector General*. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information. (2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation*. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. (2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

Subpart E—Provider Screening and Enrollment

Source: 76 FR 5968, Feb. 2, 2011, unless otherwise noted.

455.400 Purpose.

This subpart implements sections 1866(j), 1902(a)(39), 1902(a)(77), and 1902(a)(78) of the Act. It sets forth State plan requirements regarding the following:

(a) Provider screening and enrollment requirements.

(b) Fees associated with provider screening.

(c) Temporary moratoria on enrollment of providers.

455.405 State plan requirements.

A State plan must provide that the requirements of §455.410 through §455.450 and §455.470 are met.

455.410 Enrollment and screening of providers.

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other States.

455.412 Verification of provider licenses.

The State Medicaid agency must—

(a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.

(b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

455.414 Revalidation of enrollment.

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

455.416 Termination or denial of enrollment.

The State Medicaid agency—

(a) Must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.

(b) Must deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(c) Must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State.

(d) Must terminate the provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(e) Must terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(f) Must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under §455.432, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(g) May terminate or deny the provider's enrollment if CMS or the State Medicaid agency—(1) Determines that the provider has falsified any information provided on the application; or (2) Cannot verify the identity of any provider applicant.

455.420 Reactivation of provider enrollment.

After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the State Medicaid agency must re-screen the provider and require payment of associated provider application fees under §455.460.

455.422 Appeal rights.

The State Medicaid agency must give providers terminated or denied under §455.416 any appeal rights available under procedures established by State law or regulations.

455.432 Site visits.

The State Medicaid agency—

(a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.

(b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.

455.434 Criminal background checks.

The State Medicaid agency—

(a) As a condition of enrollment, must require providers to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

(b) Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid program. (1) Upon the State Medicaid agency determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the State Medicaid agency's criteria hereunder for criminal background checks as a "high" risk to the Medicaid program, the State Medicaid agency will require that each such provider or person submit fingerprints. (2) The State Medicaid agency must require a provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, in a form and manner to be determined by the State Medicaid agency, within 30 days upon request from CMS or the State Medicaid agency.

455.436 Federal database checks.

The State Medicaid agency must do all of the following:

(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

(c)(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and (2) Check the LEIE and EPLS no less frequently than monthly.

455.440 National Provider Identifier.

The State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

455.450 Screening levels for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level

of “limited,” “moderate,” or “high.” If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(a) *Screening for providers designated as limited categorical risk*. When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following: (1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination. (2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with §455.412. (3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with §455.436.

(b) *Screening for providers designated as moderate categorical risk*. When the State Medicaid agency designates a provider as a “moderate” categorical risk, a State Medicaid agency must do both of the following: (1) Perform the “limited” screening requirements described in paragraph (a) of this section. (2) Conduct on-site visits in accordance with §455.432.

(c) *Screening for providers designated as high categorical risk*. When the State Medicaid agency designates a provider as a “high” categorical risk, a State Medicaid agency must do both of the following: (1) Perform the “limited” and “moderate” screening requirements described in paragraphs (a) and (b) of this section. (2)(i) Conduct a criminal background check; and (ii) Require the submission of a set of fingerprints in accordance with §455.434.

(d) *Denial or termination of enrollment*. A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its—(1) Application denied under §455.434; or (2) Enrollment terminated under §455.416.

(e) *Adjustment of risk leve*l. The State agency must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs: (1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State’s Medicaid program within the previous 10 years. (2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

455.452 Other State screening methods.

Nothing in this subpart must restrict the State Medicaid agency from establishing provider screening methods in addition to or more stringent than those required by this subpart.

455.460 Application fee.

(a) Beginning on or after March 25, 2011, States must collect the applicable application fee prior to executing a provider agreement from a prospective or re-enrolling provider other than either of the following: (1) Individual physicians or non-physician practitioners. (2)(i) Providers who are enrolled in either of the following: (A) Title XVIII of the Act. (B) Another State's title XIX or XXI plan. (ii) Providers that have paid the applicable application fee to— (A) A Medicare contractor; or (B) Another State.

(b) If the fees collected by a State agency in accordance with paragraph (a) of this section exceed the cost of the screening program, the State agency must return that portion of the fees to the Federal government.

455.470 Temporary moratoria.

(a)(1) The Secretary consults with any affected State Medicaid agency regarding imposition of temporary moratoria on enrollment of new providers or provider types prior to imposition of the moratoria, in accordance with §424.570 of this chapter. (2) The State Medicaid agency will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program. (3)(i) The State Medicaid agency is not required to impose such a moratorium if the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries’ access to medical assistance. (ii) If a State Medicaid agency makes such a determination, the State Medicaid agency must notify the Secretary in writing.

(b)(1) A State Medicaid agency may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the State Medicaid agency identifies as having a significant potential for fraud, waste, or abuse and that the Secretary has identified as being at high risk for fraud, waste, or abuse. (2) Before implementing the moratoria, caps, or other limits, the State Medicaid agency must determine that its action would not adversely impact beneficiaries’ access to medical assistance.(3) The State Medicaid agency must notify the Secretary in writing in the event the State Medicaid agency seeks to impose such moratoria, including all details of the moratoria; and obtain the Secretary’s concurrence with imposition of the moratoria.

(c)(1) The State Medicaid agency must impose the moratorium for an initial period of 6 months. (2) If the State Medicaid agency determines that it is necessary, the State Medicaid agency may extend the moratorium in 6-month increments. (3) Each time, the State Medicaid agency must document in writing the necessity for extending the moratorium.

Printed Name of Individual Practitioner _____

Signature of Individual Practitioner _____ Date _____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative _____

Title/Position _____

Address _____ Telephone Number _____

Signature of Authorized Representative _____ Date _____

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Montana Healthcare Programs Provider Enrollment Application

PROVIDER TYPE

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

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

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
_____ Healthy Montana Kids (HMK)/Children's Health Insurance Program (CHIP) only (dental providers only)
_____ Both Medicaid and HMK/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 www.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.

_____ 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 EMAIL ADDRESSES

***Note:** You must enter at least one, and may add up to five, contact email addresses. The email address for the person completing this application should be included in case there are questions regarding this Enrollment Application.

*Email Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

*Email Address _____

Email Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

Email Address _____

Email Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

Email Address _____

Email Type _____ Technical
_____ Practice
_____ Business
_____ Financial
_____ Clinical
_____ Other

Email Address _____

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

PROVIDER-BASED FACILITIES

*Montana Healthcare Programs 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 Healthcare Programs.

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 percent or more in a disclosing entity (provider); (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity (provider); (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity (provider); (d) Owns an interest of 5 percent 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 percent 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.

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 the Additional Owner/Manager Page in the Paper Enrollment Forms section on the Provider Enrollment page https://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 or Healthy Montana Kids (HMK)/CHIP?
_____ 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 _____ / _____ / _____

MEMBER DEMOGRAPHICS

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

Gender of members _____ Male _____ Female _____ Both

EARLIEST DATE OF SERVICE

*Have you already provided services to a Montana Medicaid or Healthy Montana Kids (HMK)/CHIP member?
_____ 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
Effective Date _________ / _________ / _________ Expiration Date _________ / _________ / _________

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 _____

*Email Address _____

Montana Healthcare Programs
(Medicaid, HMK *Plus*/Children's Medicaid, HMK/CHIP)
Provider Enrollment Agreement and Signature Page

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, including but not limited to policies contained in the Medicaid provider manuals, and the terms of this document.

The Provider certifies that the care, services, and supplies for which the Provider bills Medicaid will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply with the requirements concerning advance directives at 42 U.S.C. 1396a(w).

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (7/97) which is applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age, or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program and/or any activity connected with the provision of Medicaid services. All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60 must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider agrees, in accordance with federal and state laws, regulations, and policies including 45 CFR Subpart F or Part 431 pertaining to Medicaid recipients, to protect the confidentiality of any material and information concerning an applicant for or recipient of services funded with Medicaid monies. For purposes of the delivery of services under this Agreement, the Provider is a healthcare provider that must comply, as applicable, with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as adopted at 45 CFR Part 160 and Subparts A, C, and E of Part 164.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B and the enrollment and screening requirements of 42 CFR, Part 455 Subpart E, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes, site visits, criminal background checks, federal database checks, enrollment screening based on provider risk category (including pre and post enrollment site visits where applicable). Please see the Disclosures, Screening and Enrollment Requirements which is part of your enrollment for more detailed information. Upon request, the Provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively the Department for the rate period.

The Provider agrees to notify the Montana Fiscal Agent at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought.

The Provider, if meeting the applicable criteria, agrees to comply with 42 U.S.C. 1396a (a) (68) of the Social Security Act requiring employee education about the federal False Claims Act. This provision applies to those providers furnishing items or services at more than a single location or under more

than one contractual or other payment arrangement and receiving aggregate payments of Medicaid monies totaling $5,000,000 or more annually. It is the responsibility of the Provider to establish written policies for all employees that include detailed information about the False Claims Act and the other provisions named in 42 U.S.C. 1396a(a)(68)(A).

I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND AND AGREE TO COMPLY WITH ALL DISCLOSURES, SCREENING AND ENROLLMENT REQUIREMENTS AS REQUIRED UNDER 42 CFR 455 SUBPARTS B AND E.

Printed Name of Individual Practitioner _____

Signature of Individual Practitioner _____ Date _____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative _____

Title/Position _____

Address _____ Telephone Number _____

Signature of Authorized Representative _____ Date _____

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Montana Healthcare Programs Reminders

- **Include Professional License, CLIA, and Certification**
  Include a photocopy of your professional license, CLIA, and applicable certification.

- **Include IRS W-9 Form**
  Include your completed, signed, and dated IRS W-9 form, found at https://www.irs.gov/forms-pubs/irs-section-508-compliant-pdf-forms.

- **Complete the Trading Partner Agreement**

  The Trading Partner Agreement is mandatory and must be submitted electronically.

  Complete the Trade Partner agreement on the Conduent EDI website at

  https://conduent.formstack.com/forms/conduent_edi_solutions_inc_tpa_and_baa_form_montana_medicaid

Montana Medicaid

Electronic Funds Transfer (EFT)

Authorization Agreement

The following information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the payer to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Electronic Funds Transfer Program.

Please make arrangements with the financial institution receiving the EFT to ensure proper delivery of payments for services provided.

All fields on this form are **required** in order to enroll in electronic funds transfer and to ensure proper delivery of your electronic remittance advice.

Any changes to EFT banking information will require verbal authorization. After submission of this form, the Owner, Authorized Representative or Manager (as listed on the enrollment record) will be contacted for verbal authorization prior to the completion of any requested changes.

If you have any questions about this form, contact Conduent Provider Relations at (800) 624-3958 (In/Out of State) or (406) 442-1837 (Helena).

Provider Name:_____
(The legal name of institution, corporate entity, practice, or individual provider)

Provider Address:_____

_____

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

_____

National Provider Identifier (NPI), Atypical Number, or Passport Number:

_____

Information Required	Current Account Information (Required if you are an existing provider with banking information currently on file with Montana Healthcare Programs)	New Account
Financial Institution Name		
Type of Account (checking, savings)		
Financial Institution Routing Number		
Provider's Account Number		

Reason for Submission: _____**New Enrollment** _____**Change EFT**

Montana Medicaid

Electronic Funds Transfer (EFT)

Authorization Agreement

I, _____hereby certify that the account indicated on this form is under my direct control and access; therefore, I authorize Conduent as fiscal agent for the State of Montana to make the changes indicated below.

This authority is to remain in full force and effect until the State of Montana has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford the State of Montana a reasonable opportunity to act upon it.

Written Authorized Signature of Person Submitting This Form:

_____

Submission Date:

_____

Title of Person Submitting This Form:

_____

Requested Effective Date:

_____

When complete, fax this form to: (406) 442-4402 or (888) 772-2341 or
Mail To: Provider Relations, PO Box 4936, Helena, MT 59604

Primary Care Case Management Program Enrollment for Passport to Health and Team Care

Section 1. Legal Authority

Enrollment in Passport to Health (the program) under this addendum shall be part of the provider's Montana Healthcare Programs' enrollment 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 Montana Healthcare Programs' enrollment with respect to participation or provision of services under Montana Health Care Programs. The provider(s) hereby agrees to comply with all applicable laws, rules and written policies including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM), written Department of Public Health and Human Services (Department) policies, policies contained in provider manuals, and the terms of this document.

Section 2. General Statement of Purpose and Program Goals

The purpose of this addendum is to obtain Primary Care Case Management (PCCM) services for designated members enrolled in Montana Health Care Programs from the contracting provider to deliver, coordinate, and make referrals to other Montana Health Care Programs providers as necessary. The goal of the Passport to Health program is to assure access to primary care, establish a "medical home" for the member, improve continuity of care, encourage preventive health care, promote Early and Periodic Screening Diagnosis and Treatment (EPSDT), as well as decrease or reduce non-emergent care in the emergency department or inappropriate use of medical services and medications.

Team Care, a sub-program of Passport to Health, is a utilization control program for a smaller number of members who demonstrate the need for additional case management measures. Team Care is designed to educate members how to effectively use the Montana Health Care Program system. All Passport providers are also Team Care providers. Members appropriate for Team Care can be identified through Drug Utilization Review (DUR), claims data, fraud and abuse referrals, or referrals from a Montana Medicaid provider. Team Care members are managed by a team consisting of the Passport Primary Care Prover (PCP), one pharmacy (all prescriptions for Team Care members must be written to the assigned pharmacy), the nurse advice line, and Montana Medicaid.

The nurse advice line is a nurse triage line provided by the Department, available to all Montana Health Care Program members. The line is available twenty-four hours a day, seven days a week and is free to members. Callers can be triaged by a registered nurse for illness or injury, ask general health questions and receive information about medications or treatments. If a Passport member calls the nurse advice line, and is triaged for illness or injury, a triage report is faxed to the member's Passport provider (to the fax number provided in this agreement). Passport providers are encouraged to inform members about the benefits of using the nurse advice line, especially if unsure whether they need to seek medical care. The toll-free number for the nurse advice line is 1-800-330-7847.

A PCP may be an individual physician or mid-level provider (General Practice, Family Practice, Internal Medicine, Pediatrics, Geriatrics, Clinical Nurse Specialist, Nurse Practitioner, or Physician Assistant), a Federally Qualified Health Care Center (FQHC), a Rural Health Clinic (RHC), or Indian Health Service (IHS).

Term: This agreement shall become effective upon signature of the provider or facility and shall remain in effect until otherwise amended or terminated pursuant to the terms of this agreement.

Section 3. Requirements to Provide Primary Care Case Management Services (General Terms and Conditions)

1. Must enroll or be enrolled as a Montana Medicaid provider.
2. Must comply with all applicable Federal and State laws and regulations.
3. Must agree to practice the provisions in, and sign the agreement for participation as a PCP in the program, which includes policy, information, and meeting the general requirements outlined in the *Montana Medicaid Passport to Health Provider Manual*.
4. Must accept members, including voluntary and auto-assignments, in the order in which they are enrolled.
5. Must develop an ongoing relationship with Passport members for the purpose of providing continuity of care.
6. Must provide primary and preventive care, health maintenance, treatment of illness and injury, and coordination of members' access to medically necessary care, by providing referrals and follow-up.
7. Must provide preventive services including, well child checkups, EPSDT services, lead screenings, annual wellness visits and immunizations to members on the PCP's caseload unless the member has moved.
8. Must educate members about the appropriate use of office visits, urgent care clinics, and the emergency department (ED).
9. Must not discriminate on the basis of health status or need for health care services.
10. Must not discriminate against members enrolled on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.
11. Must provide for arrangements with, or referrals to, physicians and other practitioners to ensure that services can be furnished to members promptly and without compromising quality of care.
12. Must maintain a patient medical record for each Passport member and provide appropriate HIPAA compliant exchange of information among providers. Upon a member's written request, providers must transfer the members medical records to the members new PCP.
13. Must maintain a written record of all referrals given and received for every Passport member assigned to the PCP.
14. Must provide or arrange for suitable coverage for needed services, consultation, and approval of referrals promptly during normal business hours including 24-hour availability of information, referral, and treatment for emergency medical conditions. This includes coverage during vacations, illnesses and all other absences.
15. Must not distribute any marketing material for the purpose of enrollment without first obtaining approval from the Department.
16. Must not, directly or indirectly, engage in door-to-door, telephone, e-mail, texting, or other cold-call marketing activities.
17. Must not conduct direct or indirect marketing activities specifically intended to influence members to enroll with the PCP or disenroll from another PCP.
18. Must make available reasonable appointment availability based on routine, preventive, urgent, or emergent care needs.
19. Must respond to requests from the Department for verification that specific services paid were authorized by the PCP.
20. Refer members to the Team Care program whose utilization of services is excessive or inappropriate with respect to medical need.
21. Offer interpreter services for all members with limited English proficiency. Interpreter services are covered by Medicaid. For forms and information, contact Montana Health Care Programs at (406) 444-4540.
22. Must notify the Department and/or the Department's Fiscal Agent, in writing of any changes in practice (i.e. no longer providing PCP services, change location).

Section 4. Enrollment, Disenrollment and Reenrollment of Members

1. Enrollment in the Passport to Health program is as follows:
    a. Montana Medicaid members eligible (see the *Montana Medicaid Passport to Health Provider Manual* for a list of ineligible groups) for the program are sent information explaining the program and encouraging them to choose a Passport provider. The letter includes a list of possible PCP's. The list is generated to suggest the best possible provider for the member.
    b. If the member fails to choose a Passport provider, the Department will assign a provider. The assignment is based on previous Passport enrollment, claims history, family Passport enrollment, tribal affiliation, and providers with open slots on their caseload within close proximity to the member's home.
    c. A member who loses Montana Medicaid eligibility for two months or less will be automatically re-enrolled to the last provider chosen or assigned.
2. Members may request a change in PCP without cause in writing, with the Medicaid Member Help Line or at http://mtpassport.com once a month. In most cases, the change will not be effective until the following month.
3. The PCP may disenroll a member by providing 30 days' written notice to the member and to the Department. The PCP is required to provide the member with services or referrals for 30 days post disenrollment, to ensure access to continuous care. A PCP may not disenroll a member due to a change in the member's health status or utilization of medical services, diminished mental capacity or uncooperative behavior resulting from special needs, except when such behavior disrupts or seriously impairs the ability to furnish services to the member or other members, or for failure to pay co-pays or other bills. A PCP may disenroll a member for any of the following reasons:
    a. the provider/member relationship is mutually unacceptable;
    b. the member has not established care, after outreach attempts have been made by the provider;
    c. the member is seeking primary care elsewhere;
    d. the member fails to follow prescribed treatment;
    e. the member is physically/verbally abusive or uncooperative;
    f. the member could be better treated by a different type of provider, and a referral process is not feasible; or
    g. the member consistently fails to show up for appointments.

Section 5. Passport Enrollee Lists

A monthly Passport list will be mailed to each Passport provider (to the address provided in this agreement) by the first day of each month. A Team Care list will accompany the Passport list if applicable. The Team Care list will include the name of the member's pharmacy to which all prescription must be written.

Section 6. Provider Clinic Requirements

Providers of health care services that are either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider are required to participate in the Passport and Team Care programs. Further, they must:

1. accept auto-assignment;
2. not limit or restrict Montana Health Care Programs members unless the same limits or restrictions apply to non-Medicaid members;
3. accept new Montana Health Care Program members at the same rates as non-Medicaid members are accepted; and
4. only disenroll members from his or her caseload per this agreement and subject to the approval by the Department.

Section 7. Written Materials and Oral Interpretation Services

1. The PCP will make available all written information regarding the practice in easily understood language and format as well as in the prevalent non-English languages spoken in the practices service area.
2. The PCP will provide oral interpretation services for any language at no cost to the member. Interpreter services are covered by Medicaid. For forms and information, contact the Montana Health Care Program at (406) 444-4540.

Section 8. Provider Fees and Payments

1. In addition to fee-for-service reimbursement, Passport providers receive a per member, per month (PMPM) fee to provide a medical home for the Passport members assigned to their caseload. The PMPM fee is paid whether or not the provider sees the member that month. The PMPM fee is paid with the expectation that the items listed in this agreement are completed as needed for member's coordination of care.
2. Passport providers receive $3 PMPM for individuals determined categorically eligible for Aged, Blind, Disabled and Medically Frail Medicaid and $1 PMPM for all other members eligible for Passport.
3. The PMPM fee is generated by the Department and is paid to the providers under the Passport number. The Passport provider does not need to bill the Department for these services.

Section 9. Inspection and Audit of Records and Access to Facilities

The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the PCP, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the agreement period or from the date of completion of any audit, whichever is later.

Section 10. Prohibitions

PCP's are prohibited from knowingly having a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or an individual or entity who is an affiliate of a person described above.

The relationships described in this section include:

1. a director, officer, or partner of a PCP;
2. a subcontractor of the PCP;
3. a person with beneficial ownership of five percent or more of the PCP's equity; or
4. a network provider or person with an employment, consulting or other arrangement with the PCP for the provision of items and services that is significant and material to the PCP's obligations under its contract with the Department.

If the Department finds that a PCP is not in compliance with the above:

1. the Department must notify the Secretary of the noncompliance;
2. may continue an existing agreement with the PCP unless the Secretary directs otherwise;
3. may not renew or otherwise extend the duration of an existing agreement with the PCP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

Section 11. Sanctions

Pursuant to 42 CFR 438.700 and other authority, the Department may impose sanctions if it determines a PCP acts or fails to act as follows:

1. Fails substantially to provide medically necessary services that the PCP is required to provide, under law or under its agreement with the Department, to a member covered under the agreement.
2. Acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a member, except as permitted under the program, or any practice that would reasonably be expected to discourage enrollment by members whose medical condition or history indicates probable need for substantial future medical services.
3. Misrepresents or falsifies information that it furnishes to CMS or the Department.
4. Misrepresents or falsifies information that it furnishes to a member or other health care provider.
5. The Department determines that a PCP has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
6. A PCP has violated any of the other applicable requirements of sections 1903(m), 1932 or 1905(t)(3) of the Act, or any implementing regulations.
7. Fails to comply with applicable laws, rules and written policies, including, but not limited to, Title XIX of the Social Security Act, the Code of Federal Regulations, Montana Code Annotated, Administrative Rules of Montana, written Department of Public Health and Human Services policies, including policies contained in provider manuals, and the terms of this agreement.

Pursuant to 42 CFR 438.702, for any violations of this section, the Department may impose the following sanctions:

1. Civil money penalties of the following amounts.
    a. A maximum of $25,000 for each determination of failure to provide medically necessary services, misrepresentation or false statements to members or other health care providers, or marketing violations.
    b. A maximum of $100,000 for each determination of member discrimination or misrepresentation or false statement to CMS or the Department.
    c. A maximum of $15,000 for each member the Department determines was not enrolled because of a discriminatory practice (subject to the overall limit of $100,000 listed above).
2. Grant members the right to terminate enrollment without cause and notify the affected members of their right to disenroll.
3. Suspend all new enrollment, including auto-assignments, after the date the Secretary or the Department notifies the PCP of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
4. Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Before imposing any of the sanctions above, the Department must give the PCP timely written notice that explains the basis and nature of the sanction, and any other appeal rights the Department elects to provide.

Nothing in this section precludes the Department from imposing additional sanctions under state law.

Section 12. Termination

1. The Department has the authority to terminate a Passport agreement and enroll the PCP's members with another participating PCP if the Department determines the PCP has failed to:
    a. Carry out the substantive terms of this agreement; or
    b. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Act.

   Before terminating a Passport agreement, the Department must provide the PCP a pre-termination hearing. The Department must give the PCP written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing, the Department must give the PCP written notice of the decision affirming or reversing the proposed termination of the agreement and, for an affirming decision, the effective date of the termination.
2. In the case of voluntary termination by a PCP including termination of one provider in a group practice, the PCP must provide written notification to the Department 30 days prior to the termination date. If a provider leaves your practice, and you have a group Passport number, the provider must be unlinked from the Passport number. Written notification must be sent to Passport Provider Lead, P.O. Box 254, Helena, MT 59624.

Section 13. Attachments

The following attachments must be completed and submitted with this agreement to indicate the enrolling PCP understands the terms and conditions that regulate the Passport to Health Program:

1. Attachment A- Passport Provider Enrollment Information
2. Attachment B- Passport Provider Caseload Management Information

I agree to comply with the participation requirements of the Passport to Health program, as cited in this agreement. I certify that all information provided in this agreement is true, accurate, and complete.

Primary Care Provider or Authorized Representative Signature — Date

---

Form Completed by: — Title — Date

Return forms to:

Passport to Health
P.O. Box 254
Helena, MT 59624

Fax: (406) 442-2328

Attachment A
Passport Provider Enrollment Information

_____ **Solo Passport Provider:** A solo Passport provider will be enrolled in the program as an individual provider with one Passport number. The solo provider will be listed as the member's Passport provider and will be responsible for managing his or her individual caseload. PMPM fees will be paid to the individual provider under the solo provider's Passport number, separate from fee-for-service reimbursement.

Individual Provider NPI:	**Tax ID:**

_____ **Group Passport Provider:** A group Passport provider will be enrolled in the program as having one or more Medicaid providers practicing under one Passport number. The group name will be listed as the member's Passport provider. The participating providers will sign the group signature page and be responsible for managing the group's caseload. PMPM fees will be paid under the group's Passport number, separate from fee-for-service reimbursement.

Group/Clinic Provider NPI:	**Tax ID:**

Passport Provider Enrollment Information

Passport Individual/Group Provider Name:	
Physical Address (Street, City, State, Zip Code):	
Mailing Address:	
Telephone Number:	**Fax Number:**
Contact E-mail Address:	

Group Passport Primary Care Provider (PCP) Signature(s)

Each Physician and Mid-Level Practitioner employed by a group Passport clinic or Physician who will be participating as a Passport PCP, must sign this Passport Agreement, whereby the employee agrees to provide Passport primary care case management services under the terms and conditions of this Agreement in its entirety.

PCP Provider Name	PCP Provider Signature	PCP Provider Specialty	PCP Provider NPI

Attachment B
Passport Provider Caseload Management Information

The following information will be used to manage your Passport caseload. The information you provide below is not part of the Passport to Health Agreement and can be changed at any time in writing. This information will be used to assure you receive the members who are most appropriate for your practice. Information such as hours of operation and age restrictions will be provided to members to allow them to choose a PCP who best meets their needs. You cannot limit or restrict your caseload in a manner that results in discrimination of a protected class.

Passport providers will not have a caseload limit unless one is specified below.

Maximum Caseload: _____ Passport members

Ages Seen:

_____ All ages
_____ Minimum age
_____ Maximum age

Gender:

_____ Both
_____ Male
_____ Female

Office Hours:

_____ to _____ Monday
_____ to _____ Tuesday
_____ to _____ Wednesday
_____ to _____ Thursday
_____ to _____ Friday
_____ to _____ Saturday
_____ to _____ Sunday

24-Hour Phone Number and Coverage: _____

- ☐ Answering service
- ☐ Call forwarding
- ☐ On-call provider coverage
- ☐ Answering machine
- ☐ Other (specify):

Please list languages (other than English) that are spoken in your office:	

Please list any scheduling information not listed above:

Attachment B
Passport Provider Caseload Management Information

Please list any known Montana Medicaid members in your service area who have been discharged from your practice. Passport will use this information to assure these members will not be assigned to your caseload.

Montana Medicaid Member Name	Montana Medicaid Member ID

HMK/CHIP Dental
Provider Agreement and Signature Page

The Provider certifies that the information provided on this enrollment form is to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. In consideration of CHIP payments made for appropriate medically necessary services rendered to eligible claimants, and in accordance with any restrictions noted herein, the provider agrees to the following:

The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana CHIP program, including but not limited to Title XXI of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, and the terms of this document.

The Provider certifies that the care, services, and supplies for which the provider bills CHIP will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the provider is an independent contractor providing services for the Department and that neither the provider nor any of the provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply with those federal requirements and assurance for recipients of federal grants provided in OMB Standard Form 424B (7/97) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the CHIP program or any activity connected with the provision of CHIP services.

All hiring done in connection with the provision of CHIP services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider agrees, in accordance with federal and state laws, regulations and policies including 45 CFR Subpart F or Part 431 pertaining to Medicaid recipients, to protect the confidentiality of any material and information concerning an applicant for or recipient of services funded with Medicaid monies. For purposes of the delivery of services under this Agreement, the Provider is a healthcare provider that must comply, as applicable, with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as adopted at 45 CFR Part 160 and Subparts A, C, and E of Part 164.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United State Department of Health and Human Services, and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the Provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the CHIP program to which the provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error or other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively by the Department for the rate period.

The Provider agrees to notify the Montana Fiscal Agent at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., dental, eyeglasses, etc.) for which CHIP reimbursement is sought. Dental services that are covered as a medical service by the CHIP Third Party Administrative (TPA) Contract must be in accordance with the CHIP benefit plan. Claims for these dental services must be submitted to the TPA contractor and not directly to the Department.

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner _____

Signature of Individual Practitioner _____ Date _____

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative _____

Title/Position _____

Address _____ Telephone Number _____

Signature of Authorized Representative _____ Date _____

Montana Provider Relations
P.O. Box 4936
Helena, MT 59604

Comprehensive School and Community Treatment (CSCT) Services Contract

This contract contains boilerplate language that may be utilized and modified by the parties involved to specify the requirements appropriate for the School and CSCT provider. As with any legal document, your legal staff should review the contract prior to parties signing to ensure language meets the requirements of the involved parties.

SECTION 1. PARTIES.

The Parties to this Comprehensive School and Community Treatment Contract (hereinafter "Contract") are:

The Board of Trustees of School District No. _____ , _____ County, a political subdivision of the State of Montana providing public education (hereinafter "School District"), and _____, a (Corporation/Partnership/Sole Proprietor) (hereinafter "Vendor") that holds all federal and state licenses required to provide Comprehensive School and Community Treatment Services (hereinafter "CSCT"). Vendor specifically represents that it is an entity that can satisfy all federal and state medical licensure requirements to enable School District to recoup Medicaid funds for costs incurred for the provision of CSCT.

SECTION 2. PURPOSE.

The Parties enter into this Contract for the following purpose:

Vendor will provide CSCT Services, according to the terms of this contract, to all School District students authorized by the School District to receive CSCT. As used in this agreement the term CSCT means Comprehensive School and Community Treatment.

SECTION 3. TERM OF CONTRACT.

This Contract shall be effective as of _____ 20____, and shall continue in effect through _____ unless terminated earlier as provided in Section 9 below.

SECTION 4. SERVICES TO BE PROVIDED BY VENDOR.

4.1 Vendor agrees to render CSCT services to School District in accordance with the Statement of Work attached hereto as Exhibit 1 and incorporated by reference. For all students, Vendor shall submit monthly progress reports, including service documentation, supporting the provision of CSCT services.

4.2 Vendor will maintain and submit to School District sufficient documentation of services to enable School District to bill for Medicaid covered services provided to Medicaid eligible children. Vendor will bill third party insurers for all CSCT Medical services provided to non-Medicaid eligible children in the amount, scope and duration required by the Montana Department of Public Health and Human Services to satisfy third party liability requirements. For those children ineligible for Medicaid and uninsured, Vendor will bill the parents for services rendered utilizing their fee schedule.

SECTION 5. CREATION AND RETENTION OF RECORDS.

5.1 The Vendor must create and maintain records of the services covered by this contract, including financial records, supporting documents, and such other records as are required by law or other authority.

5.2 Vendor shall maintain books, records, and documents in accordance with federal and state medical documentation requirements, accounting procedures and practices which sufficiently and properly reflect the services rendered and funds expended in connection with this Contract. All service/program notes, books, medical records, documents, or other materials associated with this

Contract shall be subject to reasonable inspection, review, or audit by School District and/or the Montana Department of Public Health and Human Services and/or Centers for Medicare and Medicaid Services and their designees, during Vendor's usual business hours and upon prior notice. Vendor shall retain all medical service progress notes, student case files/medical records, financial and other records pertaining to its work under this Contract for six (6) years three (3) months from the date of the completion, termination or expiration of this Contract or the conclusion of any audit pertaining to this Contract, whichever is later. If any litigation, review, claim or audit is started before the expiration of this period, the records must be retained until all litigation, reviews, claims or audit findings involving the records have been resolved.

SECTION 6. CHANGES TO VENDOR'S WORK WITHIN STATEMENT OF WORK.

6.1 School District may, at any time by written notice, make changes in the Vendor's work within the general scope of the Statement of Work. If any change under this section causes an increase or decrease in the Vendor's cost of, or time required for, the performance of any part of the work, the parties shall negotiate an equitable adjustment to the compensation payable hereunder, and this Contract shall be modified in writing accordingly. If the Parties cannot reach a mutually agreeable adjustment after good faith negotiations either Party may terminate this contract.

6.2 The parties agree to negotiate in good faith to revise this Contract in the event of:

6.2.1 Legislation or court action that affects this Contract or State Medicaid Coverage;

6.2.2 Changes in the funds available that affect this Contract; or

6.2.3 Other changes reasonably requested by School District necessary to make this Contract consistent with federal and state Medicaid billing requirements.

If the Parties cannot reach a mutually agreeable adjustment after good faith negotiations either Party may terminate this contract.

SECTION 7. SCHOOL DISTRICT'S OBLIGATIONS.

7.1. School District agrees to provide the Vendor with office space, phone, computer, printer, Internet and email access, and reasonable office supplies.

7.2 School District agrees to provide the Vendor with the following additional services:

_____

_____

_____(If none so note.)

SECTION 8. CONSIDERATION AND PAYMENTS.

8.1. Amount of compensation. School District shall pay Vendor in accordance the Payment Schedule attached hereto as Exhibit 2. Vendor agrees that such rates shall not increase during the term of this Contract.

8.2 Manner of Payment. Vendor shall prepare and submit to School District an invoice, by the tenth (10th) day of each month, showing CSCT student load, student Medicaid eligibility status and corresponding Medicaid number if applicable, services performed for each student, and the number of days for which services were provided to the student. School District shall pay the Vendor within thirty (30) days after receipt and approval of the invoice and any required supporting documentation.

SECTION 9. TERMINATION.

9.1 This Contract may be terminated with written notice prior to the expiration of the term of the Contract for the following reasons:

9.1.1 The District may immediately terminate the whole or any part of this contract for failure to perform the contract in accordance with the terms of the contract and other governing authorities.

9.1.2 Either Party shall have the right to terminate this Contract if the other Party is in default of any obligation hereunder and such default is not cured within thirty (30) days of receipt of a notice from the non-defaulting Party specifying such default.

9.1.3 This Contract may be terminated by School District upon written notice to the Vendor if:

9.1.3.1 The Montana Department of Public Health and Human Services (DPHHS) for any reason terminates Medicaid coverage of the CSCT program in the State of Montana

9.1.3.2 The DPHHS no longer allows the School District to recoup Medicaid reimbursement for the provision of CSCT services to Medicaid eligible children; and,

9.1.3.3 Vendor does not meet federal and state CSCT licensure and service requirements.

9.2 If this contract is terminated early School District shall compensate Vendor for services performed up to the date of written notice of termination less any amounts that are the subject of a good faith dispute. In no event, however, shall the amount payable to Vendor in connection with a termination exceed the total value of this Contract as set forth on Exhibit 2.

SECTION 10. CESSATION OF SERVICES, RETURN OF PROPERTY, COMPENSATION.

10.1 Upon the expiration of the term of this Contract, or earlier termination as provided in Section 9, Vendor shall: cease to provide CSCT services hereunder, submit any outstanding monthly progress reports, including service documentation and invoices described in Sections 4 and 5, and deliver to School District all property relating to the business and work of School District. Such property shall include but not be limited to all office space, phone, computer, printer, Internet and email access, and reasonable office supplies.

10.2 Upon the expiration of the term of this Contract, or earlier termination as provided in Section 6, School District shall: compensate Vendor for services performed up to the date of written notice of termination less any amounts that are the subject of a good faith dispute. In no event, however, shall the amount payable to Vendor in connection with a termination exceed the total value of this Contract as set forth on Exhibit 2. School District's obligation to pay is contingent on the receipt from Vendor of monthly progress reports, including service documentation and invoices, and all School District property.

SECTION 11. STANDARD OF PERFORMANCE.

Vendor warrants and represents that it possesses the special skill and professional competence, licensure, expertise and experience to undertake the obligations imposed by this Contract. Vendor agrees to perform in a diligent, efficient, competent and skillful manner commensurate with the highest standards of the profession, and to devote such time as is necessary to perform the services required under this Contract. Vendor agrees to remove and replace any of its personnel who, in the sole judgment of School District, are not performing their responsibilities at an acceptable level.

SECTION 12. INDEMNIFICATION.

Vendor agrees to defend, indemnify and hold School District harmless from and against any and all claims, losses, liabilities or expenses (including, without limitation, attorneys' fees) which may arise, in whole or in part, out of (i) the negligence or willful misconduct of the Vendor, its employees or agents, and/or (ii) a breach by the Vendor of its obligations under this Contract. The indemnity required herein shall not be limited by reason of the specification of any particular insurance coverage.

SECTION 13. INSURANCE.

13.1 General Liability. The Vendor must maintain, at its cost, primary standard general liability insurance coverage. The general liability coverage must include claims arising out of contractual liability, the delivery of services, omissions in the delivery of services, injuries to persons, damages to property, the provision of goods or rights to intellectual property or any other liabilities that may arise in the provision of services under this contract. The insurance must cover claims as may be caused by any act, omission, or negligence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors.

13.1.1 The Vendor must provide general liability insurance coverage inclusive of bodily injury, personal injury and property damage. The general liability insurance coverage must be obtained with combined single limits of $_____ (_____ Dollars) per occurrence and $_____ (_____ Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A- or through a qualified self-insurer plan, implemented in accordance with Montana law and subject to the approval of the Department.

The School District, its officers, officials, agents, employees, and volunteers, are to be covered as additional insureds for liability arising out of activities performed by or on behalf of the Vendor, inclusive of the insured's general supervision of the Vendor, products and completed operations; and arising in relation to the premises owned, leased, occupied, or used by the Vendor.

THE RECOMMENDED COVERAGE FOR GENERAL LIABILITY INSURANCE IS $1,000,000 PER CLAIM AND $2,000,000 AGGREGATE PER YEAR. THE MINIMUM ALLOWABLE COVERAGE IS $_____ PER CLAIM AND $1,000,000 AGGREGATE PER YEAR. VARIATIONS MAY BE APPROVED BY THE BOARD OF TRUSTEES.

13.2 Automobile Liability Insurance.

13.2.1 Automobile insurance coverage is required when the Vendor is to transport student, when the transportation of students may occur as an activity related to the delivery of services or the delivery of services necessitates travel by Vendor or employees of the Vendor. Vendor's and School District's initials and date indicated automobile liability insurance is not required because Vendor will not transport students or travel as part of the performance of this contract.

	Initials	Date
Vendor	_____	_____
School District	_____	_____

13.2.2 If Section 13.2.1 is not initialed Vendor must provide proof of Automobile liability insurance and the following provision applies:

The Vendor must maintain, at its cost, automobile liability insurance coverage. The

insurance must cover claims as may be caused by any act, omission, or negligence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors. The Vendor must provide automobile liability insurance inclusive of bodily injury, personal injury and property damage. The automobile liability insurance coverage must be obtained with combined single limits of $_____ (_____ Dollars) per occurrence and $_____ (_____ Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A- or through a qualified self-insurer plan, implemented in accordance with Montana law and subject to the approval of the Department.

The School District, its officers, officials, agents, employees, and volunteers, are to be covered as additional insured for liability arising out of activities performed by or on behalf of the Vendor, inclusive of the Vendor's general supervision, or arising in relation to automobiles leased, hired, or borrowed by the Vendor.

THE RECOMMENDED AND MINIMUM COVERAGES ARE THE SAME AMOUNTS IDENTIFIED FOR GENERAL LIABILITY INSURANCE (SEE ABOVE).

13.3 Professional Liability Insurance. The Vendor must maintain, at its cost, professional liability insurance coverage against claims for harm to persons which may arise from the professional services provided through this contract. The insurance must cover claims as may be caused by any act, omission, or negligence of the Vendor and/or its officers, agents, employees, representatives, assigns or subcontractors, assigns or employees.

13.3.1 The Vendor must provide occurrence coverage professional liability insurance with combined single limits of $_____ (_____ Dollars) per occurrence and $_____ (_____ Dollars) aggregate per year, from an insurer with a Best's Rating of no less than A-.

THE RECOMMENDED AND MINIMUM COVERAGES ARE THE SAME AMOUNTS IDENTIFIED FOR GENERAL LIABILITY INSURANCE (SEE ABOVE).

13.3.2 In lieu of occurrence coverage, the Vendor may provide claims made coverage with three years of additional tail coverage at the discretion of the Board of Trustees.

13.3.3 The Vendor must provide to the District a copy of the certificate of insurance showing compliance with the requisite coverage. All insurance required under this contract must remain in effect for the entire contract period. The Vendor must provide to the District copies of any new certificate or of any revisions to the existing certificate issued during the term of this contract. The District may require the Vendor to provide copies of any insurance policies pertinent to these requirements, any endorsements to those policies, and any subsequent modifications of those policies.

13.3.4 The Vendor's insurance coverage is the primary insurance in respect to the School District, its officers, officials, agents, employees, and volunteers. Any insurance or self-insurance maintained by the School District and its officers, officials, agents, employees, and volunteers is in excess of the Vendor's insurance and does not contribute with it.

13.3.5 Any deductible or self-insured retention must be declared to and approved by the District. At the request of the District, the insurer must:

13.3.5.1 Reduce or eliminate such deductibles or self-insured retentions in relation to the District, its officials, employees, and volunteers; or

13.3.5.2 The Vendor must procure a bond guaranteeing payment of losses and related investigations, claims administration, and defense expenses.

SECTION 14. COMPLIANCE WITH LOCAL, STATE AND FEDERAL ORDINANCES STATUTES, REGULATIONS, RULES, AND POLICIES.

14.1 Vendor agrees to comply with all federal, state and local statutes, regulations, ordinances and rules as well as any and all School District policies and procedures relating, directly or indirectly, to vendor's performance hereunder, including but not limited to all applicable laws pertaining to licensing, civil rights, equal employment opportunity, drug-free work place, the Health Insurance Portability and Accountability Act of 1996, PL 104-91 (HIPAA) and procurement integrity.

14.2 Vendor represents that it is not presently suspended or debarred by any government agency ore regulatory agency, proposed for suspension or debarment by any government agency or regulatory agency or otherwise excluded from participating in procurement activities funded with federal monies.

14.3 The Vendor agrees to ensure compliance of its subcontractors, if any, with the applicable federal requirements and assurances.

SECTION 15. COMPLIANCE WITH LABOR LAWS.

15.1 This Contract shall not constitute, create, or otherwise imply an employment, joint venture, partnership, agency, or similar arrangement. Each Party to this Contract shall act as an independent contractor, and neither Party shall have the power to act for or bind the other Party except as expressly provided for herein.

15.2 Ineligible for Employee Benefits. Vendor and its employees shall not be eligible for any benefit available to employees of the School District, including, but not limited to, workers compensation insurance, state disability insurance, unemployment insurance, group health and life insurance, vacation pay, sick pay, severance pay, bonus plans, pension plans, savings plans and the like.

15.3 Payroll Taxes. No income, social security, state disability or other federal or state payroll tax will be deducted from payments made to Vendor under this Contract. Vendor agrees to pay all state and federal taxes and other levies and charges as they become due on account of monies paid to Vendor hereunder, and to defend, indemnify and hold School District harmless from and against any and all liability resulting from any failure to do so.

15.4 Workers' Compensation Insurance. The Vendor, at all times during the term of this contract, must maintain coverage for the Vendor and the Vendor's employees, if any, through workers' compensation, occupational disease, and any similar or related statutorily required insurance program. The Contractor must provide the School District with proof of necessary insurance coverage.

15.5 The Vendor is solely responsible for and must meet all labor, health, safety, and other legal requirements, including payment of all applicable taxes, premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Vendor and any persons providing services on behalf of the Contractor under this contract.

15.6 The provision of this contract regarding indemnification applies with respect to any and all claims, obligations, liabilities, costs, attorney fees, losses or suits accruing or resulting from the Vendor's failure to comply with this section, or from any finding by any legal authority that any person providing services on behalf of the Vendor under this contract is an employee of the School District.

SECTION 16. LIAISONS.

16.1 The liaison for the School District is:

_____

_____

_____

16.2 The liaison for the Vendor is:

_____

_____

_____

These persons serve as the primary contacts between the Parties regarding the performance of this contract.

16.3 Written notices, reports and other information required to be exchanged between the Parties must be directed to the liaison at the parties' addresses set out in this contract.

SECTION 17. MISCELLANEOUS.

17.1 Attorneys' Fees. In the event suit is brought to enforce or interpret any part of this Contract, the prevailing Party shall be entitled to recover as an element of the costs of suit, and not as damages, reasonable attorneys' fees to be fixed by the Court.

17.2 Waiver, Modification, and Amendment. No provision of this Contract may be waived unless in writing, signed by all of the parties hereto. Waiver of any one provision of this Contract shall not be deemed to be a continuing waiver or a waiver of any other provision. This Contract may be modified or amended only by a written contract executed by all of the parties hereto.

17.3 Governing Law; Venue. This Contract shall be governed and construed in accordance with the laws of the State of Montana, without regard to choice of law principles. The parties agree that the sole venue for legal actions related to this Contract shall be the state and U.S. Federal District courts in which the School District is located.

17.4 Assignment; Subcontracting. Neither this Contract nor any duties or obligations hereunder shall be assigned, transferred, or subcontracted by Vendor without the prior written approval of School District, which approval may be withheld in the sole and absolute discretion of School District.

17.5 Notices. All notices under this Contract will be in writing and will be delivered by personal service, facsimile, or certified mail, postage prepaid, or overnight courier to such address as may be designated from time to time by the relevant Party, which initially shall be the address set forth on the signature page to this Contract. Any notice sent by certified mail will be deemed to have been given five (5) days after the date on which it is mailed. All other notices will be deemed given when received. No objection may be made to the manner of delivery of any notice actually received in writing by an authorized agent of a Party.

17.6 Partial Invalidity. If any provision of this Contract is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any manner.

17.7 Publicity. Neither Party shall make any public announcement concerning this Contract without the advance approval of the other Party. Notwithstanding the foregoing, if the parties are unable to agree on a mutually acceptable announcement, a Party may nevertheless issue a press release if it is advised by counsel that such release is necessary to comply with applicable securities or similar laws.

17.8 Waiver of any default, breach, or failure to perform under this contract is not deemed to be a waiver of any subsequent default, breach or failure of performance. In addition, waiver of any default,

breach or failure to perform is not construed to be a modification of the terms of this contract unless reduced to writing as an amendment to this contract.

SECTION 18. ENTIRE CONTRACT.

This Contract contains the entire agreement and understanding of the parties with respect to the subject matter hereof, and supersedes and replaces any and all prior discussions, representations and understandings, whether oral or written. The Parties through their authorized agents have executed this contract on the dates set out below.

SCHOOL DISTRICT

By _____ Date _____

_____ as _____

Typed/Printed Name Title

VENDOR

By _____ Date _____

_____ as _____

Typed/Printed Name Title

_____

_____

Address

_____

Phone Number

Exhibit 1
Statement of Work

The Vendor will provide the School District with the following services:

1. Meet all CSCT program staffing requirements as required by the Department of Public Health and Human Services;
2. Ensure all children within the school or the School District, as appropriate, who meet the described criteria for service, are considered for admission to the program;
3. Provide a program of services staffed by at least 2 mental health workers who work exclusively in the school;
4. Ensure that at least 1 of the 2 mental health workers are a licensed psychologist, licensed clinical social worker, or licensed professional counselor.
5. The CSCT team may provide up to 720 units of service per calendar month;
6. Develop and implement a CSCT plan of care in cooperation with the School District for each enrolled child;
7. Provide treatment, crisis management and discharge planning services to enrolled children;
8. Provide regular updates of a child's plan of care to the School District and pertinent agencies;
9. Provide for family involvement in treatment and discharge planning and in the course of treatment;
10. Provide continuing contact and information exchange with persons and agencies significantly involved in the child's treatment;
11. Provide the School District with the necessary support documentation to enable School District to bill Medicaid for services provided to Medicaid eligible children;
12. Ensure that all available financial resources for support of services including third party insurance and parent payment are utilized;
13. Bill for all third parties for services provided to non-Medicaid eligible children including family members; and
14. Ensure that services delivered are adequately documented to support the reimbursement received.

Exhibit 2
Payment Schedule

School District will reimburse Vendor according to the following payment schedule:

For Medicaid eligible children receiving Medicaid covered CSCT services, $ _____dollars per day/week/month for CSCT services rendered.

It will be the responsibility of the Vendor to recoup payment for CSCT services rendered to Non-Medicaid eligible children from all third party payers following the Department of Public Health and Human Services third party liability guidelines.

For children that do not have third party insurance coverage, the Vendor agrees to bill the student or student's family following the Department of Public Health and Human Services sliding fee schedule for CSCT services provided to Non-Medicaid eligible, uninsured students.