Montana Healthcare Programs
Provider Enrollment
Rendering Providers

Thank you for choosing to enroll as a Montana Healthcare Programs and/or HMK/CHIP Dental 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. Signed material may be mailed, faxed, or securely emailed. Your application will not be processed until both application and supplemental information are received.

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 sending the supplemental material. 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.

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 enrollment 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 is the Pay-To on a claim and the individual servicing provider is the Rendering/Treating provider.

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 by sending an email to MTEnrollment@conduent.com.

Applicants who wish to change information on a submitted application or 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 reviewed, signed, and dated as applicable.

All Medicaid-Only Providers

_____ 1. Read, sign, and date the Montana Healthcare Programs Provider Enrollment Agreement and Signature Page. This application is for an individual; the individual who will be providing the service must sign.

_____ 2. 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.

_____ 3. Include a **photocopy of your applicable board certification**.

_____ 4. Complete Trading Partner Agreement to enable access to the Montana Access to Health web portal.

_____ 5. Check here if you have enrolled in Medicare, Healthy Montana Kids (HMK) and/or another State's Medicaid or CHIP Program.

Medicaid and HMK/CHIP Dental Providers

In addition to the above Medicaid-only requirements:

_____ 1. Read, sign, and date the HMK/CHIP Dental Provider Enrollment Agreement and Signature Page. This application is for an individual; the individual who will be providing the service must sign.

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 level*. 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 Rendering Provider Enrollment Application

PROVIDER TYPE

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

Audiologist	Licensed Professional Counselor	Podiatrist
Board Certified Behavior Analyst	Nurse Practitioner	Psychiatrist
Certified Nurse Midwife	Nutritionist / Dietician	Psychologist
Chiropractor	Occupational Therapist	Registered Nurse Anesthetist
Dental	Optometrist	Social Worker
Denturist	Physical Therapist	Speech Pathologist
Licensed Addiction Counselor	Physician	
Licensed Clinical Pharmacist	Physician Assistant	

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.

INDIVIDUAL PROVIDER NAME

Full name is required for individual practitioner.

*Last Name _____ *First Name _____ MI _____

_____ Miss _____ Mrs. _____ Mr. _____ Ms.

Professional Title _____

*SSN _____ *DOB _____

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 _____

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 ADDRESS

***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 ______________________

License Number State

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 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 _____ - _____

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 ____ / ____ / ____

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. _____

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 _____ / _____ / _____

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)
Rendering 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 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

Provider and Team Care Agreement Amendment to Add Primary Care Providers

New Physicians and Mid-Level Practitioners employed by a group Passport clinic 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.

Please provide the information requested below for each new PCP and fax the form to the Passport Enrollment Broker at (406) 442-2328. If you have questions, please contact the Passport Provider Lead at (406) 457-9558.

Group Passport Provider Number	**Date**

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

HMK/CHIP Dental Provider Agreement and Signature

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

Montana Healthcare Programs Reminder

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

- **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
  http://conduent.formstack.com/forms/conduent_edi_solutions_inc_tpa_and_baa_form_montana_medicaid