

**Montana Healthcare Programs
(Medicaid, HMK Plus, 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 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 _____

Attach the Montana Provider Services Mail Cover Sheet and mail to:

Department of Public Health and Human Services
Montana Healthcare Programs Provider Services
P.O. Box 89
Great Falls, MT 59403