FAX COVER SHEET

TO	Texas Medicaid and Healthcare Partnership
COMPANY	TMHP
FAX NUMBER	15125144214
FROM	Virginia Smith
DATE	2011-11-15 12:23:53 CST
RE	Kintana #4337763

COVER MESSAGE

Hello,

Attached is the PIF1 application for Dr. H. Brook Randal per TET's Kintana #4337763 request on 11/06/2011.

If you have any questions, please contact me via telephone at 1-888-737-9615, via fax at 1-888-724-3239 or via email at virginia@wholewomanshealth.com

Thank you -

Virginia Smith
Credentialing Coordinator
Whole Woman's Health

TMHP A STATE MEDICAID CONTRACTOR

P O Box 200795
Austin, TX 78720-0795
1-800-925-9126
Fax: 1-512-514-4214

WHOLE WOMANS HEALTH OF AUSTIN LLC
8401 NORTH IH 35 STE 200
AUSTIN T 78753

Kintana # 4337763

Initials: TET Date: November 6, 2011

Dear WHOLE WOMANS HEALTH OF AUSTIN LLC,

Thank you for your application to enroll in the Texas Medicaid Program. The attached forms are being returned to obtain additional information. To continue processing your application, we must receive the requested information within 30 days of the date of this letter.

If your application was submitted online through the TMHP Provider Enrollment on the Portal (PEP), you can submit updates through PEP by choosing "View Existing Transactions", selecting the portal ticket number of the application you wish to update, and clicking "Edit". After making the necessary revisions, submit the application by navigating to the "Final Acknowledgement" screen at the end of the application and click "I Accept".

If you submitted a paper enrollment application, you must submit revisions, along with a copy of this letter, to:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment Department
PO Box 200795
Austin, TX 78720-0795

Pages that do not require your signature can be faxed to 1-512-514-4214.

If you have any questions, please call the TMHP Contact Center at 1-800-925-9126, and select Option 2.

Please do not submit claims for services provided to eligible Medicaid clients until you have completed your enrollment with TMHP and received a letter with your Texas Provider Identifier (TPI). After you have received your TPI, please submit claims promptly to ensure that claims are received within 95 days of the date of your enrollment in the Texas Medicaid Program.

Your application is being returned because your application is missing information on one or more of the following documents:

11047135

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Comments:

MISSING PAGE 8.4 FOR THE BOOYAH GROUP- MUST COMPLETE AND SUBMIT.

MISSING PAGE 8.4 FOR AMY HAGSTROM- MUST COMPLETE AND SUBMIT.

MISSING PAGE 8.4 FOR T PATRICK AND ASSOCIATES- MUST COMPLETE AND SUBMIT.

MISSING PAGE 8.4 FOR THOMAS WILCOX- MUST COMPLETE AND SUBMIT.

PAGE 9.2- MUST REMOVE THE X FROM "CORPORATION" AND LEAVE ONLY THE X FOR "OTHER" LLC.

MUST COMPLETE AND SUBMIT A PIF-1 FOR EACH PERSON LISTED ON PAGE 5.4

MUST COMPLETE AND SUBMIT A PROVIDER AGREEMENT FOR EACH PERSON LISTED ON PAGE 5.4. MUST INCLUDE AN ORIIGINAL SIGNATURE FOR EACH.

MUST SUBMIT COPY OF CLIA CERTIFICATE

Thank you for participating in the Texas Medicaid Program. If you have any questions about your application, please call the TMHP Contact Center at 1-800-925-9126.

Enclosures

Provider Information Form (PIF-1)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement or other State Health-Care Program Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS or its designee

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Last, First, Middle Initial OR Group/Company name:	**Maiden name:**
Randal, H. Brook	
List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI):** *(10-digit)*
	1083642920

Primary Taxonomy Code: *(10-digit)*

207P00000X - EMERGENCY MEDICINE

Secondary Taxonomy Code: *(10-digit – the provider may indicate up to 15 taxonomy codes; attach additional pages if needed)*

Non-Texas-enrolled Taxonomy Code: *(these codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid)*

For additional names or addresses, attach pages as necessary.

Physical address:
Number Street Suite City State ZIP

8401 N I H 35, Suite 200, Austin, TX 78753

Accounting/billing address:
Number Street Suite City State ZIP

8401 N I H 35, Suite 1 A Austin, TX 78753

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Third Party Biller ☐ Management Company ☐ Employer ☒ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Professional Licensing or Certification Board; Professional License Number and State: *(if applicable)*	Initial issue date: MM/DD/YYYY	Expiration date: MM/DD/YYYY
G3943	02/27/1983	05/31/2013
Pharmacist Immunization Certification or CCNA Certification:	**Issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY
National Registry of Rehabilitation Technology Suppliers (NRRTS)	**Issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY
Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)	**Issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY

Social Security Number:	Federal Tax ID number:
[redacted]	20-0627390
Specialty of practice: *(i.e. pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
ob/gyn	
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	State:	Driver's license expiration date: MM/DD/YYYY
[redacted]	[redacted]	[redacted]

Date of birth: MM/DD/YYYY	02/15/1951	Gender:	☐ Male	☒ Female

CLIA Number: *(attach a copy of the CLIA certification, if applicable)*
Hospitals providing laboratory services, and independent laboratories (including those located in physician's offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA address: *(list the address listed on the CLIA Certificate, if applicable)*
Number Street Suite City State ZIP

Previous Physical address:
Number Street Suite City State ZIP

Previous Accounting address:
Number Street Suite City State ZIP

Do you plan to use a Third Party Biller to submit your health-care claims?

☒ Yes ☐ No *If Yes, provide the following information about the billing agent.*

Billing agent name:	Address:
Virginia Smith	PO Box 702029 San Antonio, TX 78270
Federal Tax ID number:	
39-2055036	
Contact person name:	**Telephone number:**
Virginia Smith	1-888-737-9615

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☒ No
If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*	
Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☒ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☒ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☒ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? *(You may be subject to a license or certification verification/status check with your licensing or certification board.)*	☐ Yes ☒ No
If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*	
"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.** **Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?** *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☒ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☒ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☒ Yes ☐ No
If **No**, *of what country are you a citizen?* *If you answered* **No** *above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	