DCN: 200728540009113

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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Important Information for New Medicaid Providers

Dear Healthcare Professional:

Thank you for your interest in becoming a Texas Medicaid provider. Your participation in the Medicaid program is vital to the successful delivery of Medicaid services.

As a potential new provider to the Medicaid program, you must follow certain claims filing procedures while completing the enrollment process to be assigned a Medicaid Texas Provider Identifier (TPI) number. *This is particularly important if you render Medicaid services to clients before you receive your Medicaid TPI.*

There is no guarantee your application will be approved for processing. If you make the decision to provide services to a Medicaid client prior to approval of the application, you do so with the understanding that, if the application is denied, claims will not be payable by Medicaid and you waive the right to bill the Medicaid client for services rendered.

Provider must personally sign prior to enrollment.

I, as the Provider, understand and agree that, if I make the decision to provide services to a Medicaid client prior to approval of the application and enrollment is denied, none of the claims will be payable by Medicaid and, further, I understand and agree that by providing these services prior to enrollment, I am waiving my right to bill and agree not to bill the Medicaid client for those denied services.

Signature of Applicant/Provider

3/2/07

Date

Print Name: Regan Theiler, MD, PhD

DCN: 200728540009113

Regan Nell Theiler

Texas Medicaid Identification Form

Please check only the appropriate boxes to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to Appendix A on pages 21.1 through 21.7 of the instructions.

Legend
: ★ Medicare number required ◆ Palmetto number required
✪ Medicare number may be assigned, but not required ✚ Must designate if public provider

Traditional Services

- ☐ ★ Advanced Practice Nurse
- ☐ ★◆ Ambulance/Air Ambulance
- ☐ ★✚ Ambulatory Surgical Center (ASC)
- ☐ ★ Audiologist
- ☐ Birthing Center
- ☐ ★ Catheterization Lab
- ☐ ★ Certified Nurse Midwife (CNM)
- ☐ ★ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Chemical Dependency Treatment Facility (TCADA)
- ☐ ★ Chiropractor
- ☐ ★ Community Mental Health Center
- ☐ ★ Comprehensive Health Center (CHC)
- ☐ ★ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Dietitian
- ☐ ◆ Durable Medical Equipment (DME)
- ☐ Durable Medical Equipment / Home Health
- ☐ ◆ Family Planning Agency
- ☐ ★ Federally Qualified Health Center (FQHC)
- ☐ ★ Federally Qualified Look-alike (FQL)
- ☐ ★ Federally Qualified Satellite (FQS)
- ☐ ★✚ Freestanding Psychiatric Facility
- ☐ ★ Freestanding Rehabilitation Facility
- ☐ ◆ Genetics
- ☐ Hearing Aid
- ☐ ★ Home Health
- ☐ ★✚ Hospital — In-State
- ☐ ◆ Hospital Ambulatory Surgical Center (HASC)
- ☐ ◆ Hospital — Military
- ☐ ★✚ Hospital — Out-of-State
- ☐ ◆ Hyperalimentation
- ☐ ★✚ Independent Lab
- ☐ Licensed Professional Counselor (LPC)
- ☐ Licensed Vocational Nurse
- ☐ ◆ Maternity Service Clinic (MSC)
- ☐ ✪ Occupational Therapist (OT)
- ☐ ★ Optician
- ☐ ★ Optometrist (OD)
- ☐ ✪ Physical Therapist (PT)
- ☒ ★ Physician (MD, DO) *OB/GYN and Pediatricians not required to have a Medicare Number*
- ☐ ★ Physiological Lab
- ☐ ★ Podiatrist
- ☐ ★ Portable X-Ray
- ☐ ★ Psychologist
- ☐ ★ Radiation Treatment Center
- ☐ Radiological Lab
- ☐ Registered Nurse
- ☐ ★✚ Renal Dialysis Facility
- ☐ Respiratory Care Practitioner
- ☐ ★✚ Rural Health Clinic – Hospital, Freestanding
- ☐ ★ Skilled Nursing Facility
- ☐ ✪ Social Worker (LMSW-ACP)
- ☐ Speech Therapist
- ☐ ◆ SHARS — School, Co-op or School District
- ☐ SHARS — Non-School
- ☐ ◆ TB Clinic
- ☐ ◆ Vision Medical Supplier (VMS)
- ☒ Multi-Specialty Group

Targeted Case Management Services

- ☐ ◆ Early Childhood Intervention (ECI)
- ☐ ◆ MH Case Mgmt/MR Case Management
- ☐ MH Rehab
- ☐ ◆ Children and Pregnant Women (CPW)
- ☐ Blind Children's Vocational Discovery & Development Program
- ☐ Women, Infants & Children (WIC) — Immunization Only

Comprehensive Care Services (CCP)

- ☐ Dietitian
- ☐ Licensed Vocational Nurse
- ☐ Occupational Therapist (OT)
- ☐ Pharmacy
- ☐ Physical Therapist (PT)
- ☐ Registered Nurse
- ☐ Social Worker (LMSW-ACP)
- ☐ Speech Therapist (SLP)

Texas Health Steps (THSteps) Services (EPSDT)

Do you wish to be a THSteps provider, check appropriate box

☐ YES ☐ NO

Texas Vaccines for Children Program

Do you currently receive free vaccines from the State of Texas: ☐ Yes ☐ No *(if "no," please answer the next question.)*

Does your clinic/practice provide routinely recommended vaccines to children ages 0 to 18 years?

☐ No ☐ Yes *(if "yes," complete pages 20.1 - 20.3 of this application to become a Texas Vaccines for Children provider)*

DCN: 200728540009113

Texas Medicaid Provider Enrollment Application

- All information must be completed and contain a valid signature to be processed.
- Original signatures only; copies or stamped signatures not accepted.
- Please use blue or black ink.

APPLICANT ENROLLED AS: ☐ Individual ☑ Group ☐ Facility

SECTION A — Provider of Service Information

Existing Medicaid Texas Provider Identifiers (TPIs) *Please list all other assigned Texas Medicaid TPIs in boxes to the right* **Please list NPI and Taxonomy Codes (If available)**	2081V00000 V	1609061558	provider
	1932000004	1942241146	group

Group/Company (or Last Name)	First	Initial	Title/Degree	Do you want to be a limited provider? (See page 4)
UTMB Faculty Group Practice				☐ Yes ☑ No

Telephone Number	Social Security Number (For Individual Enrollment Only)	License Number (Copy of License/Temporary Permit Required)	Issue Date MM/DD/YY	Expiration Date MM/DD/YY
(409) 747-0890				

Date of Birth MM/DD/YY	Medicare Intermediary	Medicare Number	Medicare Certification Date MM/DD/YY
	Trailblazer Health Enterprises, LLC	00K518	01/01/75

Employer's Tax ID No.	Legal Name According to the IRS (Identical to W-9 Line 1)	Primary Specialty	Multi-Specialty
76-0010407	UTMB Faculty Group Practice	Sub-Specialty	

***Physical Address — Where services are being rendered. Number	Street	Suite	City	State	ZIP
301 University			Galveston	Texas	77555

Accounting/Billing Address — Where notification and provider information are to be sent. Number	Street	Suite	City	State	ZIP
P. O. Box 4797-710			Houston	Texas	77210-4797

Group Medicare Number:	OR	Group Texas Medicaid TPI:
00K518		109372601

Facilities Only:			
Is this a freestanding facility?	• Yes	• No	
Is this a hospital-based facility?	• Yes	• No	
Is this an ESRD facility?	• Yes	• No	
If yes, what is your composite rate?			

Hearing Aid Providers Only:			
Are you a physician?	• Yes	• No	
Are you a fitter/dispenser?	• Yes	• No	
Are you an audiologist?	• Yes	• No	
Will you be conducting evaluations?	• Yes	• No	
Will you be dispensing hearing aids?	• Yes	• No	

***Mandatory Field

Texas Medicaid Provider Enrollment Application

SECTION A *(Continued)*

School Health and Related Services (SHARS) Providers Only

If enrolling as a special education co-op, attach a list of all school districts in the co-op that will be providing SHARS services. Provide the following information for each school district:
- Complete address
- School District Number
- T.E.A. number

Are you enrolling as a school district?	• Yes	• No
If yes, give school six-digit T.E.A. number:		
Are you enrolling as a special education co-op?	• Yes	• No
If yes, give fiscal agent number:		
Are you enrolling as a non-school SHARS provider?	• Yes	• No
If yes, please attach school affiliation letter		

Hospital Providers Only

Are you a hospital facility?	• Yes	• No
	Private	Semi-Private
If yes, what is your average daily room rate?		

Public/Non-Public Providers

Definition — *Public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.*

Are you a private entity?	• Yes	✓ No
Are you a public entity?	X Yes	• No
If yes, are you required to certify expended funds?	• Yes	X No

Name and address of a person certifying expended funds:

SECTION B—GROUP PRACTICE *Individual performing providers to be added to the group*

Group Medicare Number	OR	Group 9-digit Texas Medicaid TPI
R518		109372601

Name	License Number	License Issue Date MM/DD/CC	Social Security Number	Medicare Number	Title/ Degree
ReaganNellTheiler	M6911	060507	[redacted]	858610	MD

Notification of your assigned Texas Medicaid TPI will be mailed to the Accounting/Billing address listed on your application.

Texas Medicaid Provider Enrollment Application

SECTION C — *REQUIRED INFORMATION for Specific Provider Types*

All Licensed Providers	You must attach a copy of your license and/or certification that will not expire within 30 days. If enrolled with Medicare, you must attach a copy of your Medicare Confirmation Letter.
Ambulance Services Providers	You must attach a copy of your permit/license.
Birthing Center Providers	You must attach a copy of your certification permit.
Certified Registered Nurse Anesthetist Providers	You must attach a copy of your CRNA certification or re-certification card.
Chemical Dependency Treatment Facility Providers	You must attach a copy of your license.
CLIA Providers	You must attach a copy of your CLIA license with approved specialty services as appropriate.
ECI Providers	You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention.
FQHC/FQS/FQHL	You must attach a copy of your grant award.
Mammography Services Providers	You must attach a copy of your mammography systems certification from the Bureau of Radiation Control (BRC) and enter your certification number in the box below. ***Certification Number:***
MH/MR Providers	You must attach a copy of your approval letter from the State of Texas.
Case Management for CPW Providers	You must attach a copy of your approval letter from the State of Texas.
Non-School SHARS Providers	You must attach a copy of your affiliation letter from the school district. Requirements of a valid affiliation letter are found in the *Texas Medicaid Provider Procedures manual*, School Health and Related Services (SHARS) section.

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

(Signature of applicant or an authorized representative if you are enrolling as a provider group/supplier)

Signature

M.D., PhD

Title

3/7/07

Date

HHSC Medicaid Provider Agreement

Name of Provider Regan Nell Theiler *Medicaid Provider ID Number Pending

Doing Business As UTMB Faculty Group Practice Medicare Provider ID Number 8J5K610

Physical Address 301 University

Galveston Texas 77555

Mailing Address P. O. Box 4797-710

Houston Texas 77210-4797

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. The provider manual, bulletins and notices may be accessed via the Internet at www.tmhp.com. Providers may obtain copy of the manual by calling 1-800-925-9126. Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state, federal law, amendments governing and regulating Medicaid and all pertinent Texas Administrative Code (TAC) references, to include, but not limited to, Title 1, Part 15, Chapter 371, §§371.1 – 371.1741 related to waste, abuse and fraud.

1.2 State and Federal regulatory requirements.

1.2.1 Provider and it's principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC § 1320a-7), or Executive Order 12549. Provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal healthcare program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 CFR Part 76, "Government-wide Debarment and Suspension (Non-procurement) and Government-wide Requirements for Drug-Free Workplace (Grants)."

This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to HHSC or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 CFR Part 76 by participants in lower tier covered transactions.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services, Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify HHSC or its agent within 10 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to HHSC complete information related to any such suspension or restriction.

Provider agrees to disclose all convictions of Provider or Provider's principals within 10 business days of the date of conviction. Please send the information to Office of Inspector General, P.O Box 85211 - Mail Code 1361, Austin, Texas 78708. 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. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR § 1001.2. All principals of the Provider include an owner with a direct or indirect ownership or control interest of 5 percent or more. Principals also include corporate officers and/or directors, limited or non-limited partners, or shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity. Principals further include managing employee(s) of the Provider who exercises operational or managerial control over the entity or who directly or indirectly conducts the day-to-day operations of the entity

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to keep any and all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide unconditionally, on request, access to records required to be maintained under 42 CFR § 431.107 and Title 1 TAC, Part 15, Chapter 371, Subchapter G, Division 4, § 371.1643 and copies of those records free of charge to HHSC, HHSC's agent, Office of Inspector General, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their agents access to its premises as required by Title 1 TAC, §371.1643.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Inspector General, and internal and external auditors for the state/ federal government and/or HHSC may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of Inspector General. Subcontractors are those persons or entities who provide medical or dental goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

HHSC Medicaid Provider Agreement

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to apply to Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, Social Security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25 percent ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records. Provider agrees to retain all back-up documents validating costs as required for documents in paragraph 1.2.3 and Title 1 TAC, §371.1643 and provide access to these documents and premises in accordance with the requirements in paragraph 1.2.3 and Title 1 TAC § 371.1643.

1.3 Claims and encounter data.

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are accessible and validates the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a client for a covered service.

HHSC Medicaid Provider Agreement

1.3.4 Federal law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20)

1.3.5 As a condition for eligibility for Medicaid benefits, a client assigns all rights to recover from any third party or any other source of payment to HHSC (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (Texas Administrative Code Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).

1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent and implement an effective method to track submitted claims against payments made by HHSC.

1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as the payment error is discovered.

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the HHSC Office of Inspector General (OIG). To report waste, abuse or fraud, go to www.hhs.state.tx.us and select "Reporting Waste, Abuse, or Fraud". Individuals may also call the OIG hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

2.1.1 the individual's right to self-determination in making health care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

HHSC Medicaid Provider Agreement

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult clients on the provider's policies concerning the client's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

- School health and related services (SHARS)
- Case management for blind and visually impaired children (BVIC)
- Case management for early childhood intervention (ECI)
- Service coordination for mental retardation (MR)
- Service coordination for mental health (MH)
- Mental health rehabilitation (MHR)
- Tuberculosis clinics
- State hospitals

3.2 Public schools that are the sponsoring entity for a non-school SHARS provider are required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of expenditures made by HHSC. A non-public school SHARS provider must submit an affiliation letter from the sponsoring public school acknowledging this relationship and indicating that the public school understands that it will be billed for the state portion of the fee paid to the non-public SHARS provider. Specific information regarding the requirements of a valid affiliation letter are found in the *Texas Medicaid Provider Procedures Manual*, Section 39-School Health and Related Services (SHARS).

IV. CLIENT RIGHTS

4.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

4.3 The client must have the right to choose any qualified provider of family planning services.

V. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate this Agreement by providing the other party with 30 days advance notice of intent to terminate. HHSC may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of clients at risk. HHSC may terminate this Agreement without notice if the Provider has not submitted a claim to the Medicaid program for 12 months.

HHSC Medicaid Provider Agreement

VI. THIRD PARTY BILLING VENDOR PROVISIONS

6.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

6.2 Provider must have a written contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Providers and Billers files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
- Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients. Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or it's contractor.
- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.
- Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
- Biller and Provider agree to notify the Medicaid program within 5 working days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

Provider Signature _____ Date 3-12-07

Regan Theiler

Printed Name

Certification

Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts

Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts

THIS FORM IS REQUIRED FOR ALL APPLICANTS

ATTACHMENT 1

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor, "contract" refers to both contract and subcontract.

By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.
2. The potential contractor will provide immediate written notice to the person to whom this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
3. The words "covered contract," "debarred", "suspended," "ineligible," "participant," "person," "principal," "proposal," and "voluntarily excluded," as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.
4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract?	☐ Yes	☒ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" *without modification; in all covered subcontracts and in solicitations for all covered subcontracts.*
6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.
7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Indicate in the appropriate box which statement applies to the covered potential contractor:

☒ **The potential contractor certifies, by submission of this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any federal department or agency or by the State of Texas.**

☐ **The potential contractor is unable to certify to one or more of the terms in this certification. In this instance, the *potential contractor must attach an explanation for each of the above terms to which he is unable to make* certification. Attach the explanation(s) to this certification.**

Name of Potential Contractor	Vendor ID or Social Security Number	HHSC Contract Number (if applicable)
BX	76-0010407	

Signature of Applicant/Provider	Date	Printed Name
	3/7/07	Regan Theiler

Certification

Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts

Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts

DEFINITIONS

Covered Contracts/Subcontracts

1. Any non-procurement transaction which involves federal funds (regardless of amount and including such arrangements as sub–grant and are between HHSC or its agents and another entity).
2. Any procurement contract for goods or services between a participant and a person, regardless of type, expected to equal or exceed the federal procurement small purchase threshold fixed at 10 U.S.C. 2304(g) and 41 U.S.C. 253(g) (currently $25,000) under a grant or sub-grant.
3. Any procurement contract for goods or services between a participant and a person under a covered grant, sub-grant, contract or subcontract, regardless of amount, under which that person will have a critical influence on or substantive control over that covered transaction:
   a. Principal investigators
   b. Providers of audit services required by the HHSC or federal funding source
   c. Researchers

Debarment An action taken by a debarring official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) to exclude a person from participating in covered contracts. A person so excluded is "debarred."

Grant An award of financial assistance, including cooperative agreements, in the form of money, or property in lieu of money, by the federal government to an eligible grantee.

Ineligible Excluded from participation in federal non–procurement programs pursuant to a determination of ineligibility under statutory, executive order, or regulatory authority, other than Executive Order 12549 and its agency implementing regulations; for example, excluded pursuant to the Davis–Bacon Act and its implement regulations, the equal employment opportunity acts and executive orders, or the environmental protection acts and executive orders. A person is ineligible where the determination of ineligibility affects such person's eligibility to participate in more than one covered transaction.

Participant Any person who submits a proposal for, enters into, or reasonably may be expected to enter into a covered contract. This term also includes any person who acts on behalf of or is authorized to commit a participant in a covered contract as an agent or representative of another participant.

Person Any individual, corporation, partnership, association, unit of government, or legal entity, however organized, except: foreign governments or foreign governmental entities, public international organizations, foreign government owned (in whole or in part) or controlled entities, and entities consisting wholly or partially of foreign governments or foreign governmental entities.

Principal Principals of the Provider include an owner with a direct or indirect ownership or control interest of 5 percent or more. Principals also include corporate officers and/or directors, limited or non-limited partners, or shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity. Principals further include managing employee(s) of the Provider who exercise operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

Proposal A solicited or unsolicited bid, application, request, invitation to consider or similar communication by or on behalf of a person seeking to receive a covered contract.

Sanction A recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusions, debarment, suspension, revocation, or any other synonymous action.

Suspension An action taken by a suspending official in accordance with 45 CFR. Part 76 (or comparable federal regulations) that immediately excludes a person from participating in covered contracts for a temporary period, pending completion of an investigation and such legal, debarment, or Program Fraud Civil Remedies Act proceedings as may ensue. A person so excluded is "suspended."

Voluntary exclusion or voluntarily excluded A status of nonparticipation or limited participation in covered transactions assumed by a person pursuant to the terms of a settlement

Provider Information Form (PIF-1)

Each Provider must personally complete in full the Provider Information Form (PIF-1) before enrollment in the Texas Medicaid Program. False information or pertinent omissions may result in exclusion from the Medicaid program, imposition of other sanctions, and criminal conviction. 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 must personally complete and sign this form certifying to the validity and completeness of the information provided. Provider must ensure each Principal of the Provider personally completes the Principal Information Form (PIF-2). See Principal Information Form (PIF-2) for an explanation of who meets the definition of Principal and must complete the PIF-2 Form.

For purposes of completion of the PIF-1, a "Provider" is a person or entity that when and if approved for enrollment in the Medicaid program would meet the following definition:
"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a provider agreement or contract in force with a Medicaid operating agency, and who has a provider number issued by the Commission or their designee to:

(1) provider medical assistance, Medicaid, under contract or provider agreement with the commission or its designee; or
(2) provide third party billing services under a contract or provider agreement with the Commission or its designee

A "Third Party Billing Vendor" is a person, business, or entity that submits claims on behalf of a provider, but is not the provider or an employee of the provider. For these purposes, an employee is a person for which the provider completes an IRS Form W-2 showing annual income paid to the employee. All others meet the definition of a Third Party Billing Vendor."

Last, First, Middle Name	Maiden Name
Thaler, Regan Nell	N/A

List any other Alias, Name, or Form of your name ever used: N/A

Doing Business As (DBA) Name: UTMB Faculty Group Practice

For additional names or addresses, please attach necessary pages.

Physical Address: Number Street	Suite	City	State	Zip
301 University		Galveston	Texas	77555

Accounting/Mailing Address: Number Street	Suite	City	State	Zip
P. O. Box 4797-710		Houston	Texas	77210-4797

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

☑ Billing Agent ☐ Management Company ☐ Employer ☐ Self ☒ Other (explain below)

Explain if "Other" was selected: Bank Lockbox

Licensing Board, License Number, and State	License Issue Date MM/DD/YY	License Expiration Date MM/DD/YY
Tx State BME M6911 TX	06 08 07	02 28 09

Social Security Number/TaxID	Employer's TaxID
	76-0010407

Specialty of Practice	Medicare Intermediary
06/Gyn	Trailblazer Health Enterprises, LLC

Provider Information Form (PIF-1)

Medicare Provider Number: 858610

Medicare Effective Date MM/DD/YY: 08-01-07

Driver's License Number and Issuer:

Driver's License Expiration Date MM/DD/YY:

Date of Birth MM/DD/YY:

Gender: ☐ M ☒ F

Previous Physical Address — Number: 747 | Street: Ormewood Ave SE | Suite: | City: Atlanta | State: GA | ZIP: 30312

Previous Accounting Address — Number: | Street: | Suite: | City: | State: | ZIP:

List all physical locations where Medicaid services are rendered using noted TPI(s):

N/A

Please list reason for request for an additional TPI. Please note that an additional provider Texas Provider Identifier is assigned due to a difference in one of the following: physical address, Medicare number, Provider type, Provider specialty/sub-specialty combination or tax identification number.

N/A

If requesting enrollment for a new group TPI, please list below the members joining the group:

n/a

Do you plan to use a billing agent to submit your Medicaid claims?

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

Billing Agent Name: UTMB Faculty Group Practice Financial Services

Address: P. O. Box 4797-710, Houston, Texas 77210-4797

Tax ID Number: 76-0010407

Contact Person Name: Kimberly Godfrey

Telephone Number: 409.747.1196

Provider Information Form (PIF-1)

List all Texas Medicaid TPIs under which you have billed in the past 12 months (attach additional sheets if necessary):

N/A

List all contractual relationships with medical entities and the TPIs of those entities (attach additional sheets if necessary):

n/a

"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 license or certification currently revoked, suspended or otherwise restricted? Was a board order issued indicating a violation? (You may be subjected to a license or certification verification/status check with your respective licensing or certification board.)

☐ Yes ☒ No *If yes, 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):*

Have you ever had your license or certification revoked, suspended, or otherwise restricted? Was a board order issued indicating a violation or have you voluntarily surrendered your license or certification in lieu of disciplinary action? (You may be subject to a license/certification verification/status check with your respective licensing or certification board.)

☐ Yes ☒ No If yes, fully explain the details, including date, the state where the action occurred, name of the board or agency, and any specific action against your license or certification (attach additional sheets if necessary):

Provider Information Form (PIF-1)

Have you ever been convicted of a crime (excluding minor traffic citations)? To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR § 1001.2 as described below. (You may be subjected to a criminal history check.)

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

(3) 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.

☐ 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):*

If you are obligated to pay child support via a court order, are you currently behind 30 days or more on your child support payments?

☐ Yes ☒ No *If yes, provide details (attach additional sheets if necessary):*

DCN: 200728540009113

Provider Information Form (PIF-1)

Are you a citizen of the United States?

☒ Yes ☐ No

If no, in what country are you a citizen?

MAR 14 2007

☒ By checking this box and signing this document, I declare I have read and validate the following certification/attestation statement:

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Signature of Provider

Regan Theiler

Printed or Typed Name of Provider

Subscribed and Sworn before me, Allison P. Czerwonky a Notary Public for

the State of Georgia, on the 9 day of March, 2007.

Signature of Notary Public

Georgia

State of

Notary Seal or Stamp

ALLISON P. CZERWONKY NOTARY PUBLIC DEKALB COUNTY, GA COMM. EXP. 01-05-2008

MESSAGE TO NOTARY:
PLEASE BE SURE TO COMPLETE ALL OF THE BLANKS IN THIS NOTARY STATEMENT.

REMINDER: THIS FORM MUST HAVE ORIGINAL SIGNATURES ANB BE NOTARIZED BEFORE RETURNING TO TMHP.

Ayala, Veronica C.

From: customerservice@npienumerator.com

From: customerservice@npienumerator.com
Sent: Thursday, August 23, 2007 3:37 PM
To: Ayala, Veronica C.
Subject: National Provider Identifier

A request for a National Provider Identifier for Regan Nell Theiler MD, PHD was recently submitted to https://nppes.cms.hhs.gov, and you were listed as the contact person. This is to inform you that the request was successfully processed and the following NPI has been assigned: 1609069558. The User ID you selected for this NPI is rtheiler. Please use this User ID when logging on to the National Provider System at https://nppes.cms.hhs.gov.

Practice Location:
301 University Blvd
Galveston, TX 77555-5302

Provider Taxonomies:
Taxonomy: 207V00000X
License: m6911 State: TX
Details: Obstetrics & Gynecology
This is the Primary Taxonomy.

If you have any questions about this notification you may contact the NPI Enumerator at:
NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059
1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)

You may view or change your information by logging onto the NPPES website at https://nppes.cms.hhs.gov.

Please note: If you are not the provider, you are required to inform the provider of the information in this e-mail and furnish a copy of this notification to the provider.

DCN: 200728540009113

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier
Part A Intermediary
Part B Carrier

10-4-07

September 25, 2007

UTMB FACULTY GROUP PRACTICE
P O BOX 4797 710
HOUSTON, TX 77210-4797

53060

Dear Provider:

We are pleased to inform you that your Medicare account identification number has been established. This letter is an official CMS notification regarding your personal Provider Transaction Access Number (PTAN) formerly referred to as Pin. The Privacy Act of 1974 regulates the collection, maintenance, use and dissemination of personal information by Federal executive branch agencies. As a Medicare Contractor, we are required to comply with the Privacy Act and related regulations concerning disclosures and we are prohibited from releasing any information regarding the processing of your application or the PTAN assigned to you. It is at your discretion with which you choose to share this information; however you might use this letter as confirmation of your Medicare enrollment when dealing with other insurance programs and carriers such as Medicaid. This provider number is your personal account number and should be used on all bills and correspondence. The PTAN also will only be required when calling Customer Service and on general written inquiries. When new providers enroll in the Medicare program, they will receive a PTAN and an NPI number.

This requirement will remain in effect until further notice is received from CMS. CMS will determine when submitted claims must contain the NPI. Once a decision is made to require NPIs on claims, providers will be notified in advance via the TrailBlazer Web site and listserv when submitted claims must contain the NPI.

Tax ID Number	**760010407**
Group PTAN	**00R518**
Individual PTAN	**8J8610**
NPI	**1609069558**
Participation Status	**Participation**
Specialty	**16**
Effective Date	**8/1/2007**
Name	**THEILER REGAN N** **P O BOX 4797 710** **HOUSTON, TX 77210-4797**

Please verify all of the above information and if changes are necessary, immediately contact the appropriate Medicare Provider Enrollment Helpline and NPPES listed below:

TrailBlazer Health Enterprises, LLC℠
Provider Enrollment Department – (866) 526-1802
PO Box 650544 • Dallas, TX 75265-0544
Executive Center III • 8330 LBJ Freeway • Dallas, TX 75243-1213
A CMS Contracted Intermediary and Carrier

TEXAS MEDICAL BOARD

PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN INFORMATION

NAME: REGAN NELL THEILER MD **DATE:** 10/10/2007

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Date of Birth: 1973
License Number: M6911
Issuance Date: 06/08/2007
Expiration Date of Physician's Annual Registration Permit: 02/28/2009

Registration Status: ACTIVE
Disciplinary Status: NONE
Licensure Status: NONE

Registration Date: 06/28/2007
Disciplinary Date: NONE
Licensure Date: NONE

Mailing Address:
2017 AVE N 1/2
GALVESTON, TX 77550

Medical School of Graduation:
At the time of licensure, TMB verified the physician's graduation from medical school as follo
5605 - UNIV OF WISCONSIN MED SCH, MADISON

Medical School Graduation Year: 2003

TMB Actions and License Restrictions

The Texas Medical Board has taken the following board actions against this physician. (Also included are any formal complaints filed by TMB that are currently pending before the State C Administrative Hearings).

DCN: 200919820003342

UNIVERSITY OF TEXAS MEDICAL BRANCH
Department of Obstetrics and Gynecology, Division of Revenue, Audit, and Reports
301 University Boulevard, Route 1078, Galveston, Texas 77555-1078
(409) 772-7812 Fax (409) 772-7726

July 10, 2009

July 10, 2009

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

Dear Sir or Madam:

Enclosed are Provider Enrollment Application(s) for the following provider(s) and the group they are to be added to: Please note this provider has changed clinic locations.

Regan Theller, MD Group Number: 138740914

If there any discrepancies, please contact me at (409)-772-7812

Thank you,

Tasia Rodriguez
Manager of Patient Accounts- Provider Enrollment

Enclosures

Texas Medicaid Identification Form

Please check only the appropriate boxes to ensure proper enrollment. For assistance in choosing the appropriate provider type, please refer to Appendix A on pages 21.1 through 21.8 of the instructions.

Legend: * Medicare number required; ○ Medicare number may be assigned, but not required; ◆ Palmetto number required; ◆ Must designate if public provider

Traditional Services

- ☐ * Advanced Practice Nurse
- ☐ *◆ Ambulance/Air Ambulance
- ☐ *◆ Ambulatory Surgical Center (ASC)
- ☐ * Audiologist
- ☐ Birthing Center
- ☐ * Catheterization Lab
- ☐ * Certified Nurse Midwife (CNM)
- ☐ * Certified Registered Nurse Anesthetist (CRNA)
- ☐ Chemical Dependency Treatment Facility
- ☐ * Chiropractor
- ☐ * Community Mental Health Center
- ☐ * Comprehensive Health Center (CHC)
- ☐ * Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Consumer Directed Services Agency (CDSA)
- ☐ Dentist
- ☐ ◆ Durable Medical Equipment (DME)
- ☐ Durable Medical Equipment / Home Health
- ☒ ◆ Family Planning Agency
- ☐ * Federally Qualified Health Center (FQHC)
- ☐ * Federally Qualified Look-alike (FQL)
- ☐ * Federally Qualified Satellite (FQS)
- ☐ *◆ Freestanding Psychiatric Facility
- ☐ * Freestanding Rehabilitation Facility
- ☐ ◆ Genetics
- ☐ HCSSA
- ☐ Hearing Aid
- ☐ * Home Health
- ☐ *◆ Hospital — In-State
- ☐ ◆ Hospital Ambulatory Surgical Center (HASC)
- ☐ ◆ Hospital — Military
- ☐ *◆ Hospital — Out-of-State
- ☐ ◆ Hyperalimentation
- ☐ *◆ Independent Diagnostic Testing Facility
- ☐ *◆ Independent Lab
- ☐ Licensed Marriage and Family Therapist (LMFT)
- ☐ Licensed Professional Counselor (LPC)
- ☐ ◆ Maternity Service Clinic (MSC)
- ☐ MH Rehabilitation Services
- ☐ ○ Occupational Therapist (OT)
- ☐ * Optician
- ☐ * Optometrist (OD)
- ☐ Personal Assistant Services
- ☐ ○ Physical Therapist (PT)
- ☐ * Physician (MD, DO) *OB/GYN and Pediatricians not required to have a Medicare Number*
- ☐ * Physician Assistant
- ☐ * Physiological Lab
- ☐ * Podiatrist
- ☐ * Portable X-Ray
- ☐ * Psychologist
- ☐ * Radiation Treatment Center
- ☐ Radiological Lab
- ☐ *◆ Renal Dialysis Facility
- ☐ Respiratory Care Practitioner
- ☐ *◆ Rural Health Clinic – Hospital, Freestanding
- ☐ * Skilled Nursing Facility
- ☐ ○ Social Worker (LCSW)
- ☐ ◆ SNARS — School, Co-op or School District
- ☐ SNARS — Non-School
- ☐ Service Responsibility Option (SRO)
- ☐ ◆ TB Clinic
- ☐ * Vision Medical Supplier (VMS)
- ☐ Multi-Specialty Group

Case Management Services

- ☐ ◆ Early Childhood Intervention (ECI)
- ☐ ◆ MH Case Mgmt/MR Case Management
- ☐ MH Rehab
- ☐ ◆ Case Management for Children and Pregnant Women (CPW)
- ☐ Blind Children's Vocational Discovery & Development Program
- ☐ Women, Infants & Children (WIC) — Immunization Only

Comprehensive Care Services (CCP)

- ☐ Dietitian
- ☐ Licensed Vocational Nurse
- ☐ Occupational Therapist (OT)
- ☐ Pharmacy (please refer to the definition of Pharmacy in the Enrollment Requirements by Provider Type Section)
- ☐ Physical Therapist (PT)
- ☐ Registered Nurse
- ☐ Social Worker (LCSW)
- ☐ Speech Therapist (SLP)

Texas Health Steps (THSteps) Services (EPSDT)

☐ I do not wish to participate as a provider for THSteps preventative medical check ups

Texas Vaccines for Children Program

Do you currently receive free vaccines from the Texas Vaccines For Children Program?: ☐ Yes ☐ No *(If "no," please answer the next question.)*

Does your clinic/practice provide routinely recommended vaccines to children ages birth through 18 years?

☐ No ☐ Yes *(If "yes," complete pages 20.1 - 20.3 of this application to become a Texas Vaccines for Children provider)*

DCN: 200919820003342

Texas Medicaid Provider Enrollment Application

- All information must be completed and contain a valid signature to be processed. If a question or answer does not apply, enter "N/A"
- Original signatures only; copies or stamped signatures not accepted.
- Please use blue or black ink.

REQUESTING ENROLLMENT AS: ☐ Individual ☒ Group ☐ Facility ☐ Performing Provider

SECTION A — Provider of Service Information

Existing Medicaid Texas Provider Identifiers (TPIs) Please list all other assigned Texas Medicaid TPIs in boxes to the right ***Please list Group NPI and Primary Taxonomy Code		
	7116A0005Y	1568549632

*Group/Company or Last Name	First	Initial	Title/Degree	Do you want to be a limited provider? (See page 4)
UTMB Regional Maternal and Child Health Program				☒ Yes ☐ No

*Provider business e-mail	Business website address (URL)

*Telephone Number	Social Security Number (For individual provider only)	Professional Medical License Number (Copy of License/Temporary License Required)	Professional License Issue Date MM/DD/YY	Professional License Expiration Date MM/DD/YY
409-772-7812				

*Date of Birth MM/DD/YY	Medicare Intermediary	Medicare Number	Medicare Certification Date MM/DD/YY
	N/A	N/A	N/A

*Employer Tax ID No.	*Legal Name According to the IRS (Must match the legal name and tax ID number you provide)	*Primary Specialty	Sub-Specialty
76-0583205	UTMB Regional Maternal and Child Health Program	Family Planning	

*Physical Address — Where Medicare Services are Rendered Number	Street	Suite	City	State	ZIP
110 24th St North			Texas City	TX	77590

*Accepting New Clients (yes or no)	Counties Served	Client Age Restrictions	Gender Restrictions
YES	Gal/Chamb	B-45	Female Only

*Accounting/Billing Address — Where provider information is sent Number	Street	Suite	City	State	ZIP
301 University Blvd.	Route 1078		Galveston	TX	77555-1078

*Physical Address Fax Number	Accounting/Billing Address Fax Number
409 643 8207	409 772 7726

*Group Medicare Number	OR	Group Texas Medicaid Number
		13874091 4

*Mandatory Field

DCN: 20091982003342

Texas Medicaid Provider Enrollment Application

Facilities Only	Is this a freestanding facility?	☐ Yes	☐ No
	Is this a hospital-based facility?	☐ Yes	☐ No
	Is this an ESRD facility?	☐ Yes	☐ No
	If yes, what is your composite rate?		
Hearing Aid Providers Only	Are you a physician?	☐ Yes	☐ No
	Are you a fitter/dispenser?	☐ Yes	☐ No
	Are you an audiologist?	☐ Yes	☐ No
	Will you be conducting evaluations?	☐ Yes	☐ No
	Will you be dispensing hearing aids?	☐ Yes	☐ No
School Health and Related Services (SHARS) Providers Only If enrolling as a school district, list all campuses/charter schools that will be providing SHARS services. Provide the following information for each school district: • Campus address • School district's Nonpayee • T.E.A. number	Are you enrolling as a school district?	☐ Yes	☐ No
	If yes, give school six-digit T.E.A. number:		
	Are you enrolling as a non-school SHARS provider?	☐ Yes	☐ No
	If yes, please attach school affiliation letter		
Hospital Providers Only	Are you a hospital facility?	☐ Yes	☐ No
	If yes, indicate the type of hospital facility.	☐ Children's ☐ Long Term ☐ Private Full Care ☐ Psychiatric ☐ State Owned	☐ Teaching Facility ☐ Short Term ☐ Private Outpatient ☐ Rehabilitation ☐ Private / ☐ Semi-private
	If yes, what is your average daily room rate for private and semi-private?		
Public/Non-Profit Providers (governmental providers)	***Definition — Public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.***		
	Are you a private or public entity?	☐ Private	☒ Public
	If yes, are you required to certify expended funds?	☐ Yes	☒ No
	Non-governmental providers are private entities, not public entities.		

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Texas Medicaid Provider Enrollment Application

SECTION B — Owners, Partners, Officers, Directors, and Principals

Identify sole proprietor or owners, partners, officers, directors, and principals (as defined in Principal Information Form (PIF-2)) of the applicant by providing, social security number, date of birth, driver's license # and state, and list the percentage of ownership, if applicable. As it relates to owners, include all individuals with 5% or more ownership in the company, whether this ownership is direct or indirect.

Name	Title	Social Security Number	Date of Birth MM/DD/YY	Drivers License Number	% Owned

SECTION C—GROUP PRACTICE *Required if enrolling as a GROUP PRACTICE*

Indicate the type of group enrollment you are requesting by checking one of the following:

☒ Adding additional performing provider(s) to an existing group *(Indicate Group TPI below)*

☐ Enrolling a new group with performing provider(s)

Group's 10-digit Texas Medicaid TPI	OR	Group Medicare Number (if applicable)

List All Providers That Will Be Performing Services as Part of This Group.

Name	Date of Birth MM/DD/YY	Registration (License) Number	Profession (Lic.) Issue Date MM/DD/YY	Social Security Number	Medicare Number	Title/ Degree
Regan Theiler		M6911	04/08/97		NP	MD

Notification of your assigned Texas Medicaid TPI will be mailed to the Physical address listed on your application

Texas Medicaid Provider Enrollment Application

SECTION D — *REQUIRED INFORMATION for Specific Provider Types*

All Licensed Providers	If enrolled with Medicare, you must attach a copy of a current Medicare Remittance Advice Notice (MRAN).
Ambulance Services Providers	You must attach a copy of your permit/license.
Birthing Center Providers	You must attach a copy of your certification permit.
Certified Registered Nurse Anesthetist Providers	You must attach a copy of your CRNA certification or re-certification card.
Chemical Dependency Treatment Facility Providers	You must attach a copy of your license.
CLIA Providers	You must attach a copy of your CLIA license with approved specialty services as appropriate.
ECI Providers	You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention.
FQHC/FQS/FQHL	You must attach a copy of your grant award.
Mammography Services Providers	You must attach a copy of your mammography systems certification from the Bureau of Radiation Control (BRC) and enter your certification number in the box below. *Certification Number:*
MH/MR Providers	You must attach a copy of your approval letter from the State of Texas.
Case Management for Children and Pregnant Women Providers	You must attach a copy of your approval letter from the State of Texas
Non-School SHARS Providers	You must attach a copy of your affiliation letter from the school district. Requirements of a valid affiliation letter are found in the *Texas Medicaid Provider Procedures Manual*, School Health and Related Services (SHARS) section.
Out of State Providers	You must submit proof of meeting one of the following criteria prior to being able to enroll with the Texas Medicaid program: o Services are more readily available in the state where the client is temporarily located o The customary or general practice for clients in a particular locality is to use medical resources in the other state (this is limited to providers located in a state bordering Texas). The following are subject to a 90 day enrollment: o A medical emergency documented by the attending physician or other provider o The client's health is in danger if he or she is required to travel to Texas o All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency). o Other out-of-state medical care may be considered when prior authorized. o Medicare primary, Medicaid secondary for coinsurance and/or deductible payments only Refer to the Texas Provider Procedures Manual at www.tmhp.com for further information regarding out of state enrollment.

HHSC Medicaid Provider Agreement

Name of Provider Regan Theiler TPI Number

Medicare Provider ID Number

Physical Address 1104 20th St. North Texas City, TX 77590

Accounting/Billing Address (if applicable) 301 University Blvd RT 1078 Galveston TX 77550-1078

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A CD of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. The Provider Manual, bulletins and notices may be accessed via the Internet at www.tmhp.com. Providers may obtain a copy of the manual by calling 1-800-925-9126. Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws governing or regulating Medicaid, and provider further acknowledges and agrees that the provider is responsible for ensuring that all employees and agents of the provider also comply. Provider is specifically responsible for ensuring that the provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to waste, abuse and fraud, and provider acknowledges and agrees that the provider and its principals will be held responsible for violations of this agreement through any acts or omissions of the provider, its employees, and its agents. For purposes of this agreement, a principal of the provider includes all owners with a direct or indirect ownership or control interest of 5 percent or more, all corporate officers and directors, all limited and non-limited partners, and all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company. Principals of the provider further include managing employee(s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

1.2 State and Federal regulatory requirements.

1.2.1 By signing this agreement, Provider certifies that the provider and it's principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal healthcare program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal contracts and grants.

HHSC Medicaid Provider Agreement

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, at least 10 business days before making such changes. Provider also agrees to notify HHSC or its agent within 10 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to HHSC complete information related to any such suspension or restriction.

Provider agrees to disclose all convictions of Provider or Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Send the information to Office of Inspector General, P.O Box 85211 - Mail Code 1361, Austin, Texas 78708. Fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s).

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all audit or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1643. Provider understands and agrees that payment for goods and services under this agreement is conditioned on the existence of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If provider fails to create, maintain, or produce such records in full accordance with this Agreement, provider acknowledges, agrees, and understands that the public monies paid the provider for the services are subject to 100% recoupment, and that the provider is ineligible for payment for the services either under this agreement or under any legal theory of equity.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Inspector General (OIG), and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the Texas Health and Human Services Commission's Office of Inspector General or it's designee. Subcontractors include those persons and entities who provide medical or dental goods or services for which the Provider bills the Medicaid program, and those who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and encounter data.

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

1.3.5 As a condition of eligibility for Medicaid benefits, a client assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (Texas Administrative Code Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).

HHSC Medicaid Provider Agreement

1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent, and to implement an effective method to track submitted claims against payments made by HHSC or its agents.

1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the HHSC Office of Inspector General (OIG). To report waste, abuse or fraud, go to www.hhs.state.tx.us and select "Reporting Waste, Abuse, or Fraud". Individuals may also call the OIG hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

2.1.1 the individual's right to self-determination in making health care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult clients on the provider's policies concerning the client's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

- School health and related services (SHARS)
- Case management for blind and visually impaired children (BVIC)
- Case management for early childhood intervention (ECI)
- Service coordination for mental retardation (MR)
- Service coordination for mental health (MH)
- Mental health rehabilitation (MHR)
- Tuberculosis clinics
- State hospitals

3.2 A school district that is the sponsoring entity for a non-school SHARS provider is required to reimburse HHSC, according to established HHSC procedures, the non-federal portion of payments to the nonschool SHARS provider, since nonschool SHARS providers are paid the lesser of the provider's billed charges and 100% of the published fee for the service (i.e., both federal and state shares). To enroll in the Texas Medicaid Program, a nonschool SHARS provider must submit in its enrollment packet an affiliation letter that meets the requirements in Texas Medicaid Provider Procedures Manual, School Health and Related Services.

IV. CLIENT RIGHTS

4.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

4.3 The client must have the right to choose any qualified provider of family planning services.

V. THIRD PARTY BILLING VENDOR PROVISIONS

5.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

Provider must have a written contract with any person or entity for the purpose of billing provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

- Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.
- Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.
- Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.
- Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or it's contractor.

HHSC Medicaid Provider Agreement

- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.
- Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.
- Biller and Provider agree to notify the Medicaid program within 5 business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

VI. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the termination date, if any, indicated in the enrollment correspondence issued by HHSC or its agent. If the correspondence/notice of enrollment from HHSC or its agent states a termination date, this agreement terminates on that date with or without other advance notice of the termination date. If the correspondence/notice of enrollment from HHSC or its agent does not state a termination date, this agreement is open-ended and remains effective until either a notice of termination is later issued or termination occurs as otherwise provided in this paragraph. Either party may terminate this Agreement voluntarily and without cause, for any reason or for no reason, by providing the other party with 30 days advance written notice of termination. HHSC may immediately terminate this agreement for cause, with or without advance notice, for the reason(s) indicated in a written notice of termination issued by HHSC or its agent. Cause to terminate this agreement may include the following actions or circumstances involving the provider or involving any person or entity with an affiliate relationship to the provider: exclusion from participation in Medicare, Medicaid, or any other publicly funded health care program; loss or suspension of professional license or certification; any circumstances resulting in ineligibility to participate in Texas Medicaid; any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program; and any circumstances indicating that the health or safety of clients is or may be at risk. HHSC also may terminate this agreement due to inactivity, with or without notice, if the Provider has not submitted a claim to the Medicaid program for 12 or more months.

VII. ACKNOWLEDGEMENTS AND CERTIFICATIONS

By signing below, Provider acknowledges and certifies to all of the following:

- Provider has carefully read and understands the requirements of this agreement, and will comply.
- Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the provider information forms (PIF-1) and principal information form (PIF-2), and provider certifies that this information is current, complete, and correct.
- Provider agrees to inform HHSC or its designee, in writing and within 10 business days, of any changes to the information submitted in connection with its application to participate in the Medicaid program, whether such change to the information occurs before or after enrollment.
- Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.
- Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment, and may also result in other administrative sanctions that include payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Provider Signature MR18 Date 7/9/09

Regan Theiler, MD

Printed Name

DCN: 200919820003342

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.

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

(1) provide medical assistance, Medicaid, under contract or provider agreement with the Commission or its designee; or
(2) provide third party billing services under a contract or provider agreement with the Commission 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.

Legal Entity Name OR Group/Combo Name: Theiler, Regan NPI

DBA Name: N/A

Billing Entity Alias Name or Former Entity Name (Overflow): N/A

National Provider Identifier (NPI) (10 digits): 1609069558

Primary Taxonomy Code (10 digits): 261QA0005X

Secondary Taxonomy Code (10 digits): The provider may indicate up to 15 secondary codes, if applicable, on additional pages if needed.

Non-Texas Enrollee Taxonomy Code:

For additional names or addresses, please attach necessary pages.

Physical Address (Number & Street, Suite, City, State, Zip): 1164 30th St Norma Texas City TX 77590

Accounting/Billing Address (Number & Street, Suite, City, State, Zip): 320 University Blvd RT 1078 Galveston TX 77555

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

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

Explain the Other Type of Entity:

DCN: 2009198200003342

Provider Information Form (PIF-1)

Professional Licensing Board, Practitioner License Number, and State: MD, M6911, TX

Other Professional Licensing Board, Practitioner License Number, and State:

Initial Issue Date: 06/05/07

Current Expiration Date: 02/28/11

Social Security Number:

Employer ID: 76-0583205

Specialty or Medical Examination Type (if applicable): OB GYN

Medicare Provider Number: N/A

Medicare Effective Date (MM/DD/YY): N/A

Driver License Number / State Issued:

Driver License Expiration Date (MM/DD/YY): 6/2011

Date of Birth (MM/DD/YY):

☐ M ☒ F

CLIA Number (Lab must comply with CLIA certification):

CLIA Address (Is the address listed on the CLIA Certificate): Number, Street, Suite, City, State, ZIP

Previous Physical Address: Number, Street, Suite, City, State, ZIP

Previous Accounting/Billing Address: Number, Street, Suite, City, State, ZIP

Do you plan to use a Third Party Biller to submit your Medicaid billing?

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

Billing Agent Name:

Address:

State ID Number:

Contact Person Name:

Telephone Number:

List all Providers and medical entities that you have a contractual relationship with and intend to bill the NH Medicaid Program. Provider Identifier, API or TPI, and Provider Identity:

☐ 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):*

Provider Information Form (PIF-1)

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 on 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? ☐ Yes ☒ No

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 below and which includes deferred adjudications and all other types of pretrial diversion programs. (You may be subject to criminal history checks.)

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.

☐ 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 (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.

DCN: 200919820003342

TEXAS MEDICAL BOARD

PO BOX 2079 • AUSTIN, TEXAS 78768-2079

PHYSICIAN FULL PERMIT

PHYSICIAN FULL PERMIT

LICENSE/ PERMIT NUMBER	EXPIRATION DATE
M6911	02-28-2011

REGAN NELL THEILER, MD
2017 AVE N 1/2
GALVESTON TX 77550-8019

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE
PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

DCN: 200732039000084
NOV-16-07 10:24 AM ProviderEnrollment 409 747 1023 P.01

UTMB

UTMB Faculty Group Practice Financial Services

UTMB Faculty Group Practice Financial Services
123-25th Street, Shearn Moody Plaza, 2nd Floor
Galveston, TX 77555-1022

Facsimile Cover Letter

Date:	11-16-07	**Time:** 9:15	**# of Pages (Incl. Cover)** 2
To:	Provider Enrollment	**Company/Dept:**	TMH ?
Phone:	800-925-9126	**Fax:**	512-514-4214
From:	Linda L Nally	**Department:**	Provider Enrollment
Telephone:	409-747-0890	**Fax:**	(409) 747-1023
Name of UTMB Personnel Sending Fax (print):			

Please add this information to the application for Dr. Regan Theller. Kintana # 3275926

Thank you,

Linda L Nally

DCN: 200732039000084

TEXAS CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE

Texas Department of Public Safety

Criminal Law Enforcement Division, Narcotics Service

Controlled Substances Registration, PO Box 4087 Austin, Texas 78773

Criminal Law Enforcement Division, Narcotics Service

Controlled Substances Registration, PO Box 4087 Austin, Texas 78773

NO. 53705	10/31/2008	EXEMPT
(2,2N,3,3N,4,5)	PRACTITIONER	07/30/2007

REGAN NELL THEILER MD
OB/GYN DEPARTMENT MC 0587
UNIV TEXAS MEDICAL BRANCH
301 UNIVERSITY BLVD
GALVESTON TX 77555

THE STATE OF TEXAS

TEXAS MEDICAL BOARD

P.O. BOX 2018 • AUSTIN, TEXAS 78768-2018

PHYSICIAN PERMIT

LICENSE PERMIT NUMBER
M6911

EXPIRATION DATE
02-28-2009

REGAN NELL THEILER, MD
2017 AVE N 1/2
GALVESTON TX 77550-8019

THIS CERTIFIES THAT THE LICENSEE/PERMIT HOLDER NAMED AND NUMBERED HEREON HAS PROVIDED THIS BOARD THE INFORMATION REQUIRED AND HAS PAID THE FEE FOR REGISTRATION FOR THE PERIOD INDICATED ABOVE
PLEASE KEEP THIS BOARD NOTIFIED OF CHANGE OF ADDRESS

K-3275924

Tex.
27726

DCN: 200921739001424

08-05-2009 10:59 From-OB/GYN BILLING 4097727726 T-016 P.001/003 F-088

UTMB
The University of Texas Medical Branch

Facsimile Cover Letter

The University of Texas Medical Branch
Ob/Gyn Division of Revenue, Audit, and Reports
301 University Blvd. Route 1078
Galveston, TX 77555-1078
409-772-0872
409-772-7726

Date: 8/5/09 Time: 10:40 # of pages (incl. Cover): 3

Recipient Information

To: TMHP- Provider Enrollment

Telephone: Fax: 512-514-4214

Sender Information

Print Name: *(Name of UTMB personnel sending fax)* Angela Bird

UTMB Authorized Sender: (e.g. name of physician, nurse authorizing fax)

Telephone: 409-772-7723 Fax: 409-772-7726

Comments: Kintana # 3702456 page no. 3
Regan Theiler

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.

If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is **Strictly Prohibited**. If you have received this message by error, please notify the sender immediately to arrange for return or destruction of these documents.

DCN: 200921739001424

08-05-2009 10:59 From-OB/GYN BILLING 4097727726 T-016 P.002/003 F-088

Texas Medicaid Provider Enrollment Application

SECTION B — Owners, Partners, Officers, Directors, and Principals

Identify sole proprietor or owners, partners, officers, directors, and principals (as defined in Principal Information Form (PIF-2)) of the applicant by providing, social security number, date of birth, driver's license # and state, and list the percentage of ownership, if applicable. As it relates to owners, include all individuals with 5% or more ownership in the company, whether this ownership is direct or indirect.

Name	Title	Social Security Number	Date of Birth MM/DD/YY	Drivers License Number	% Owned

SECTION C—GROUP PRACTICE *Required if enrolling as a GROUP PRACTICE*

Indicate the type of group enrollment you are requesting by checking one of the following:

☒ Adding additional performing provider(s) to an existing group *(Indicate Group TPI below)*

☐ Enrolling a new group with performing provider(s)

Group 9-digit Texas Medicaid TPI: 138749017 OR Group Medicaid Number (If applicable):

List All Providers That Will Be Performing Services as Part of This Group

Name	Date of Birth MM/DD/YY	Professional License/Certificate Number	Provider's License Issue Date MM/DD/YY	Social Security Number	Medicaid Number	Title/ Degree
Rayan Theler		M0411	06/08/17		NA	MD

Notification of your assigned Texas Medicaid TPI will be mailed to the Physical address listed on your application

DCN: 200921739001424

08-05-2009 11:00 From-OB/GYN BILLING 4097727726 T-016 P.003/003 F-088

No Overlay

0 Notes

DCN:
20092053900073O

Provider First:
REGAN

Provider Last:
THEILER

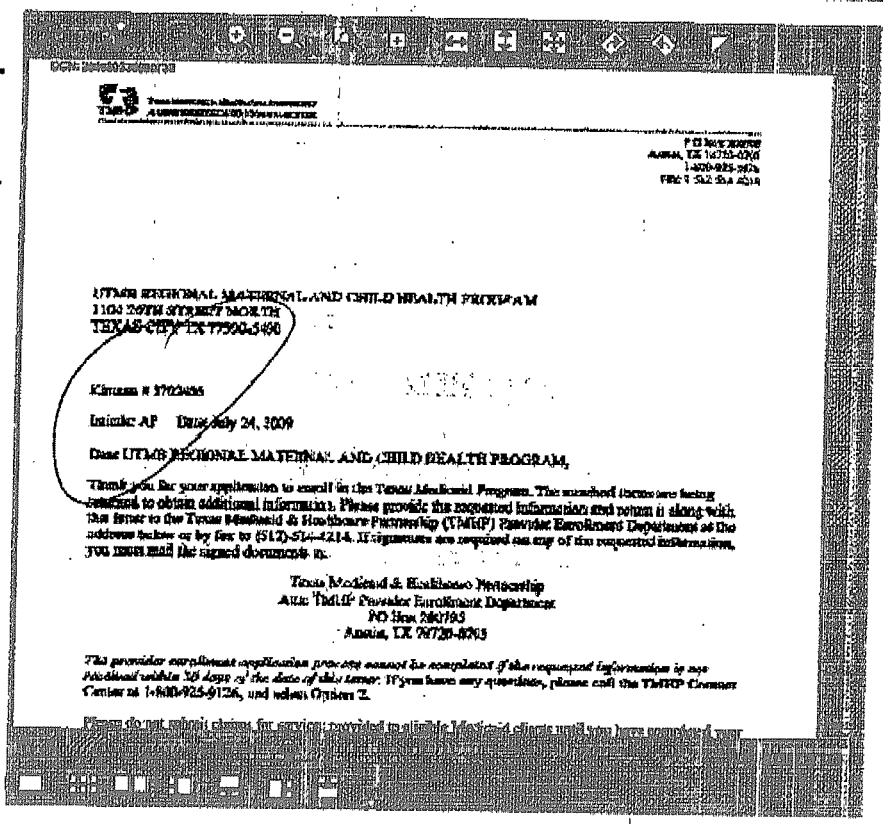
Kiteva ID:
3702456

PEP_ID:
10256921

NPI/API:
1609069558

BatchID:
BCUM090/240204

SIR Store Time:
7/24/2009 9:48:02 AM



UTMB REGIONAL MATERNAL AND CHILD HEALTH PROGRAM
1103 29TH STREET NORTH
TEXAS CITY TX 77590-5490

Kiteva # 3702456

Initials: AP Date: July 24, 2009

Dear UTMB REGIONAL MATERNAL AND CHILD HEALTH PROGRAM,

Thank you for your application to enroll in the Texas Medicaid Program. The searched items are being returned to obtain additional information. Please provide the requested information and return it along with the letter to the Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Department at the address below or by fax to (512)-514-4214. If signatures are required on any of the requested information, you must mail the signed documents in.

Texas Medicaid & Healthcare Partnership
Attn: TMHP Provider Enrollment Department
PO Box 200765
Austin, TX 78720-0765

The provider enrollment application process cannot be completed if the requested information is not furnished within 30 days of the date of this letter. If you have any questions, please call the TMHP Customer 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

Session Time Remaining: 60 minutes.

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
TMHP A STATE MEDICAID CONTRACTOR

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

UTMB Faculty Group Practice
301 University
Galveston, TX 77555

KINTANA # 3275926

Initials: NG Date: 10/9/2012

Thank you for your application to enroll in the Texas Medicaid Program. The attached forms are being returned for additional information. Please provide the requested information and return along with this letter to the TMHP Provider Enrollment Department at the above address or by fax to 1-512-514-4214. If signatures are required, you must mail the forms. **The provider enrollment application process cannot be completed if the requested information is not received within 30 days of the date of this letter. If you have any questions, please call 1-800-925-9126 and select option 2.**

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

☐ **PLEASE CLARIFY HOW WE ARE TO ENROLL YOU BY CHECKING APPROPRIATE BOX-(ES) ON PG 2**

The Texas Health and Human Services Commission (HHSC) require a Medicare number and Medicare Letter for the following Provider Types. (Please check the appropriate boxes)

____ Physicians ____ CRNA ____ Hospital/Facility
____ Home Health ____ PHD ____ Other _____
____ DME/Hyperalimentation 10 digit Palmetto #
____ Performing provider in a group with Medicare

Section A for all providers (pg. 7-1 to pg.7-2 or pg. 2 on the dental application)

☐ Name should be that of the individual, group or facility applying
☐ Social Security number is required for individuals
☐ License number and issue date in month/day/year format are required for individuals and licensed Entities
☐ CRNA requires both licenses (Nurse's License and either CCNA or Recertification Card)
☐ Medicare information is required for individuals and entities as indicated on pg. 2 (see legend)
☐ Employer's Tax ID Number is the number, under which, we report disbursements to the IRS
☐ Legal Name According to the IRS (the name must match the number on the IRS records as reported on the W-9)
☐ Need Physical Address. (P.O. Boxes are not an acceptable physical address)
☐ Answer questions pertaining to specific provider type (RHC, ESRD, PWI, ECI, HAID, Hospital, & SHARS)

Add information requested to the pages in your application as noted below.

Section B for individuals enrolling into a group or a supervising physician for Texas Health Steps (THSteps). (pg. 7-2 or pg. 2 on the dental application) (Each person listed in this section should also have an agreement and provider information form attached.)

- ☐ License number and issue date in month/day/year format are required.
- ☐ CRNA requires both licenses (Nurses License and either a CCNA or Recertification Card).
- ☐ Social Security number required for individuals enrolling in a group.
- ☐ Medicare Numbers required for individuals enrolling into a group with Medicare.

Section C for all providers (pg. 7-3)

- ☐ Please sign/re-sign pg. 7-3
- ☐ Attach a current copy of the provider's license and/or certification that will not expire within 30 days

Provider Agreement must be completed and signed by all practitioners/individuals/ groups who are applying. (All pages of the Agreement must be present- this is a contract). (pg. 8-1 thru 8-7)

- ☐ Individual name/group needs to be indicated (pg. 8-1)
- ☐ Please check Yes or No. Please re-sign (pg. 8-7)
- ☐ Signature is missing. Please sign/re-sign (pg 8-6 and/or pg. 8-7)
- ☐ Please check one of the two blocks and re-sign (pg. 8-7)
- ☐ The signature on pg. 8-6 needs to match the signature on pg. 8-7. Please sign/re-sign.

Provider Information Form (pg. 9-1 to 9-5)

- ☐ A Provider Information Form (PIF) must be completed for each practitioner/individual group applying.
- ☐ Include pg. 9-4 or pg. 5-5 with an original signature of provider and notarization as a part of each PIF
- ☐ Indicate your driver's license number, issuer (state) and expiration date in MM/DD/YY format. (pg. 9-2) Or (pg. 5-1 or pg. 5-3).
- ☐ Complete all questions. You must answer "yes" or "no" (N/A is not acceptable)
- ☐ Original signature is required for notary. Please sign/re-sign. (pg.9-4 and pg.5-5).
- ☐ **Handwritten notary expiration date requires a letter of proof from state**

Principle Information Form 2(pg. 9-6 to 9-10)

- ☐ A Principle Information Form (PIF) must be completed for each person that meets the definition of principle on Page 9-6.
- ☐ Include pg. 9-10 with an original signature of principle and notarization as a part of each PIF-2
- ☐ Indicate your driver's license number, issuer (state) and expiration date in MM/DD/YY format. (pg. 9-7).
- ☐ Complete all questions. You must answer "yes" or "no" (N/A is not acceptable)
- ☐ Original signature is required for notary. Please sign/re-sign. (pg.9-10).
- ☐ **Handwritten notary expiration date requires a letter of proof from state**

Disclosure of Ownership (pg. 10 to 11-1 & pg. 11-2)

- ☐ Name of entity on pg 7-1, pg. 11-1 and top line of W-9 must match.
- ☐ Complete the entire Disclosure of Ownership form and answer all questions with a "yes" or "no".
- ☐ Select one type of entity, must match entity on W-9
- ☐ Need an original signature (pg. 11-1 and pg. 11-2)
- ☐ All questions must be answered (pg. 11-1 and pg. 11-2)

IRS W-9 (pg. 12)
- ☐ Tax ID# on pg. 7-1 must match Tax ID# listed on W-9
- ☐ Signature is missing. Please sign
- ☐ Indicate TIN# **OR** SS# (only one number)
- ☐ Indicate EXEMPT on W-9
- ☐ Address is required

Corporate Board of Directors Resolution (pg. 14)
- ☐ Entire form must be completed
- ☐ Must be notarized
- ☐ Original signatures are required including notaries. Please sign/re-sign
- ☐ Application must be signed/re-signed by individual given authority on pg. 14.

Electronic Funds Transfer (pg. 19)
- ☐ Provider Name and Accounting Address
- ☐ Bank Name, Address, City, State, and Phone Number
- ☐ Type of Account (checking or savings)
- ☐ ABA/Transit Number
- ☐ Account Number
- ☐ Signature and Date
- ☐ Attach a copy of voided check/deposit slip or a letter from your bank for explanation

Additional Forms
- ☐ Medicaid Audit Information
- ☐ Dental Specialty Form
- ☐ Certificate of Good Standing
- ☐ Copy of CLIA with correct physical address
- ☐ Copy of certification of Mammography/Cert Number
- ☐ Copy of approval letter from TDH Case Management
- ☐ JCAHO accreditation approval form
- ☐ Encounter rate letter from Medicare
- ☐ Enclosed is the new application to enroll a performing provider into an existing group
- ☐ Electronic Remittance and Status (ER&S) Agreement
- ☐ Texas Vaccines for Children Program (TVFC) Provider Enrollment
- ☐ Certificate of Formation/Certificate of Filing
- ☐ Medicare Letter

Out of State Providers must meet certain criteria as follows prior to being able to enroll with the Texas Medicaid program as stated in Section 2.5 of the 2006 Texas Medicaid Provider Procedures Manual. Please indicate which criteria you meet:
- ☐ A medical emergency documented by the attending physician or other provider.
- ☐ The client's health is in danger if he or she is required to travel to Texas.
- ☐ Services are more readily available in the state where the client is located.
- ☐ The customary or general practice for clients in a particular locality is to use medical resources in the other state.
- ☐ All services provided to adopted children receiving adoption subsidies (these children are covered for all services, not just emergency).
- ☐ Other out-of-state medical care may be considered when prior authorized.
- ☐ Other: Please explain.

Please respond with a signed letter indicating which criteria the provider meets as well as submitting documentation as proof that one of the six criteria have been met. Please fax this deficiency letter as well as all other documentation to 512-514-4214.

Comments: Please submit a current copy of the physician permit for Regan Theiler that shows an expiration date that will not expire within 30 days; website verification is not acceptable.

Thank you for participating in the Texas Medicaid Program. If you have any questions regarding your application, please call TMHP Contact Center at 1-800-925-9126 and select Option 2.

Sincerely,

TMHP Provider Enrollment

Enclosures

DCN: 200920539000739

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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

UTMB REGIONAL MATERNAL AND CHILD HEALTH PROGRAM
1104 20TH STREET NORTH
TEXAS CITY TX 77590-5490

Kintana # 3702456

Intitals: AP Date: July 24, 2009

Dear UTMB REGIONAL MATERNAL AND CHILD HEALTH PROGRAM,

Thank you for your application to enroll in the Texas Medicaid Program. The attached forms are being returned to obtain additional information. Please provide the requested information and return it along with this letter to the Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Department at the address below or by fax to (512)-514-4214. If signatures are required on any of the requested information, you must mail the signed documents to:

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

The provider enrollment application process cannot be completed if the requested information is not received within 30 days of the date of this letter. 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:

DCN: 200920539000739

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Texas Medicaid Identification Form

☐ Please clarify how we are to enroll you by checking the appropriate boxes.

Section A Provider of Service Information

☐ Please provide a valid National Provider Identifier (NPI)/Atypical Provider Identifier (API).

☐ The entity type for the NPI does not match the type of provider enrolled with TMHP. The NPI Final rule defines an Entity type 1 as a person and Entity type 2 as providers that are organizations (not individuals), such as hospitals, clinics, laboratories, ambulance companies, and provider groups.

☐ Please provide the primary taxonomy code.

☐ The name of the group, company, or last name should be that of the individual, group, or facility that is applying.

☐ The Social Security number (SSN) is required for individuals.

☐ The professional license number and the issue date, in MM/DD/YY format, are required for individuals and licensed entities.

☐ A Certified Respiratory Nurse Anesthetist (CRNA) must provide both licenses (a nurse's license and either Council on Certification of Nurse Anesthetist (CCNA) license or CCNA Recertification Card).

☐ The selections you made on the Texas Medicaid Identification Form require that you provide your Medicare information.

☐ The employer's Taxpayer ID Number (TIN) is the number we use to report disbursements to the Internal Revenue Service (IRS).

☐ The legal name must match the number reported on the IRS W-9 Form and the Disclosure of Ownership and Control Interest Statement.

☐ Please provide the physical address. PO Boxes are not an acceptable physical address.

☐ Answer all of the questions that pertain to your specific provider types (facility, hearing aid, School Health and Related Services [SHARS], and hospital providers).

Section B Owners, Partners, Officers, Directors, and Principals (Each person listed in this section should also have a Principal Information Form (PIF-2) attached.)

☐ Indicate your driver's license number and issue date in the MM/DD/YY format.

☐ The SSN is required for individuals enrolling in a group.

DCN: 200920539000739

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Section C Group Practice (Each person listed in this section should also have an agreement and Provider Information Form PIF-1 attached.)
Information Form PIF-1 attached.)

☐ A professional license number and the issue date, in MM/DD/YY format, are required.

☐ A CRNA must provide both licenses (a nurse's license and either a CCNA license or a CCNA Recertification Card).

☐ An SSN is required for individuals enrolling in a group.

☐ A Medicare number is required for individuals enrolling in a group with Medicare.

Section D Required Information for Specific Provider Types

☐ Attach a current copy of the provider's professional license and/or certification that will not expire within 30 days

As stated in the Texas Medicaid Reimbursement section of the *Texas Medicaid Provider Procedures Manual* (TMPPM), out-of-state providers must meet the criteria specified in Title 1 *Texas Administrative Code* (TAC) §355.8083 before they can enroll in the Texas Medicaid Program. Please indicate which of the following criteria applies:
☐ A medical emergency has been documented by the attending physician or another provider.

☐ The client's health is in danger if he or she is required to travel to Texas.

☐ Services are more readily available in the state where the client is located.

☐ The customary or general practice for clients in a particular locality is to use medical resources in the other state.

☐ All of the services are provided to adopted children who receive adoption subsidies (these children are covered for all services, not just emergency).

☐ The out-of-state medical care has been prior authorized.

Please submit a signed letter and documentation that proves which of the six criteria the provider meets. Please fax this deficiency letter and all other documentation to (512)-514-4214.

HHSC Medicaid Provider Agreement (All of the pages of the HHSC Medicaid Provider Agreement are required-it is a contract).

☐ An individual's name or group must be provided.

☐ The signature is missing. Please sign or sign again.

DCN: 200920539000739

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Provider Information Form

☐ A Provider Information Form (PIF-1) must be completed for each practitioner/individual group that is applying.

☐ Indicate your driver's license number, issuer (state), and an expiration date in MM/DD/YY format.

☐ Complete all of the questions. You must answer "yes" or "no" (N/A is not acceptable).

Principal Information Form (PIF-2)

☐ A Principal Information Form (PIF-2) must be completed for each person that meets the definition of "principal."

☐ Indicate your driver's license number, issuer (state), and an expiration date in MM/DD/YY format.

☐ Complete all of the questions. You must answer "yes" or "no" (N/A is not acceptable).

Disclosure of Ownership and Control Interest Statement

☐ The legal name according to the IRS in Section A Provider of Service Information, the name in the Disclosure of Ownership and Control Interest Statement, and the name on the top line of the IRS W-9 Form must match.

☐ Complete the entire Disclosure of Ownership and Control Interest Statement and answer all of the questions with a "yes" or "no" (N/A is not acceptable).

☐ Select one type of entity; it must match the entity on the IRS W-9 Form.

☐ An original signature is required.

IRS W-9 Form

☐ The TIN in Section A must match the TIN listed on the Internal Revenue Service (IRS) W-9 Form.

☐ Indicate the TIN or SSN, but not both (only one number).

☐ Indicate "Exempt" on the IRS W-9 Form.

☐ The address is required.

Corporate Board of Directors Resolution

☐ The entire form must be completed.

☐ The form must be notarized.

☐ An original signature and notarization are required. Please sign or sign again.

DCN: 200920539000739

☐ The application must be signed or signed again by an individual given authority on the Corporate Board of Director's Resolution.
Director's Resolution.

☐ The notary expiration date cannot be handwritten. If it is handwritten, you must provide a letter from the state that specifies the expiration date.

Electronic Funds Transfer Authorization Agreement

☐ Please provide the provider name and accounting address.

☐ Please provide the American Bankers Association (ABA)/Transit Number.

☐ Please provide the bank name, address, city, state, and phone number.

☐ Please provide the account number.

☐ Please provide the type of account (checking or savings).

☐ Please provide the signature and date.

☐ Attach a preprinted copy of a voided check or a letter from your bank that is signed by a bank representative.

Additional Forms

☐ Please provide the Medicaid audit information.

☐ Please provide a copy of the Clinical Laboratory Improvement Amendments (CLIA) with the correct physical address.

☐ Please provide the Dental Specialty Form.

☐ Please provide a copy of the Certification of Mammography or certification number.

☐ Please provide a Certificate of Good Standing.

☐ Please provide a copy of the approval letter from Children and Pregnant Women (CPW) case management.

☐ Please provide the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation approval form.

☐ Please provide the Texas Vaccines for Children Program (TVFC) Provider Enrollment.

☐ Please provide the Certificate of Formation/Certificate of Filing.

☐ Please provide a Medicare Letter or a Medicare Remittance Advice Notice (MRAN) issued within the last 30 days.

DCN: 200920539000739

Comments:

Comments:

Page 7.3 Section C - Please list the group TPI #.

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

DCN: 200734140000062

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

K-3275926

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

12/05/2007

UTMB FACULITY GROUP PRACTICE
UTMB FACULTY GROUP PRACTICE
301 UNIVERSITY BLVD
RT. 1022
GALVESTON, TX 77555-5302

Re: New Enrollment Information

Dear Provider:
Thank you for the opportunity to process your application for enrollment in the Texas Medicaid Program. Please make a note of and verify your provider(s) information below and advise Texas Medicaid & Healthcare Partnership (TMHP) Customer Service if any corrections are needed. Thank you for your participation in the Texas Medicaid Program.

If you have any questions or need assistance, please contact TMHP Customer Service at 1-800-925-9126.

Sincerely,

TMHP Provider Enrollment

GROUP INFORMATION

Group Name:	UTMB FACULITY GROUP PRACTICE
TPI Base:	1093726
TPI Suffix:	01
NPI/API:	1942241146
Primary Taxonomy:	193200000X
Secondary Taxonomy(s):	

Benefit Code:

DCN: 200734140000062

Group Information

Group Name:	UTMB FACULITY GROUP PRACTICE
TPI Group Base:	1093726
Group Name:	UTMB FACULITY GROUP PRACTICE
TPI Group Base:	1093726
TPI Group Suffix:	01
NPI / API:	1942241146

New Provider Information

Provider Name:	THEILER, REGAN N
TPI Base:	1877284
TPI Suffix:	01
Date of Enrollment:	01-01-1977
NPI / API:	1609069558
Primary Taxonomy:	207V00000X
Secondary Taxonomy(s):	
Benefit Code:	

DCN: 200925939000032

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

PO Box 200795
Austin, TX 78720-0795
Fax: 1-512-514-4214

September 16, 2009

UTMB REGIONAL MATERNAL AND CHILD HEALTH PROGRAM
1104 20TH STREET NORTH
TEXAS CITY TX 77590-5490

Re: New Enrollment Information

Dear Utmb Regional Maternal And Child Health Program,

This letter is to notify you of your new provider enrollment information. Please make note of and verify your provider information and advise the Texas Medicaid & Healthcare Partnership (TMHP) if any corrections are needed.

A benefit code may be issued by TMHP to identify state programs and provider types. It is important to remember your benefit code when one has been assigned. It will be required for claims filing, requesting prior authorization, and other electronic transactions with TMHP. A benefit code may also be used to crosswalk a National Provider Identifier (NPI) or an Atypical Provider Identifier (API) to the appropriate Texas Provider Identifier (TPI) for specific state programs and provider types such as those listed in the table below.

Benefit Code	Benefit Code Description
CA1	County Indigent Health Care Program (CIHCP)
CCP	Comprehensive Care Program
CSN	Children with Special Health Care Needs (CSHCN) Services Program
DEI	Texas Health Steps (THSteps) Dental
DM2	Durable Medical Equipment — Home Health Services (DMEH)

Benefit Code	Benefit Code Description
DM3	Children with Special Health Care Needs (CSHCN) Services Program Durable Medical Equipment
EC1	Early Childhood Intervention (ECI) Provider
EP1	Texas Health Steps (THSteps) Medical
FP3	Family Planning Agencies

DCN: 200925939000032

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Benefit Benefit Code	Benefit Code Benefit Code Description
HA1	Hearing Aid Dispensers
MA1	Maternity

Benefit Benefit Code	Benefit Code Benefit Code Description
MH2	Mental Health (MH) Case Management
TB1	Tuberculosis (TB) Clinics

A list of newly enrolled performing providers in your group is on the following page(s).

Be sure to read the enclosed welcome letter for more resources that are available to you through TMHP. If you have any questions or need assistance, please call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Group Information:

Group Name:	Utmb Regional Maternal And Child Health Program
Texas Provider Identifier (TPI) Base:	1387409
TPI Suffix:	14
NPI/API:	1568549632
Primary Taxonomy:	261QA0005X
Secondary Taxonomy(s):	
Benefit Code:	FP3

Enclosures

DCN: 200925939000032

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

New Provider Information

Program Name	Traditional Medicaid
Provider Type	Family planning clinic
Provider Name	REGAN N THEILER
TPI Base	1877284
TPI Suffix	02
Enrollment Date	9/15/2009
Effective Date	8/6/2008
NPI/API	1609069558
Primary Taxonomy	261QA0005X
Secondary Taxonomy	
Benefit Code	FP3

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Dear Provider:

Welcome to Texas State Health-Care Programs! We look forward to building a strong working relationship with you. Your participation in these programs demonstrates your dedication and commitment to improving the health of Texas families.

The Texas Medicaid & Healthcare Partnership (TMHP), which is a coalition of contractors headed by Affiliated Computer Service, Inc. (ACS) under contract with the Texas Health and Human Services Commission (HHSC), serves as the claims administrator for the Texas Medicaid Program and the Children with Special Health Care Needs (CSHCN) Services Program. TMHP also acts as the administrator for the state's Medicaid managed care Primary Care Case Management (PCCM) health plan. TMHP enrolls providers, processes health-care claims, publishes Medicaid and CSHCN Services Program policy and procedure information, and conducts provider education and training.

TMHP offers a variety of convenient ways to access help, information, and services, including:

Publications

Provider Procedures Manuals—The *Texas Medicaid Provider Procedures Manual (TMPPM)* and the *CSHCN Services Program Provider Manual* are comprehensive guides to Medicaid and CSHCN Services Program benefits, policies, and procedures. They contain general information for the Texas Medicaid Program and the CSHCN Services Program, information for specific provider types, forms, examples of completed forms, and other useful reference materials. Reading, understanding, and following the instructions in the provider manuals is essential for filing claims and avoiding problems. The manuals are published every year and sent to providers on a compact disc. Portable document format (PDF) versions are also available on the TMHP website at www.tmhp.com. Texas Medicaid Program providers who do not have access to a computer can request a paper copy of the manual by calling the TMHP Contact Center at 1-800-925-9126. CSHCN Services Program providers can request a paper copy of the manual by calling the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Bulletins, Banner Messages, and Website Articles—Updates and changes to policies and procedures in the TMPPM and the *CSHCN Services Program Provider Manual* are published in the bimonthly *Texas Medicaid Bulletin* and the quarterly *CSHCN Services Program Provider Bulletin* and mailed to providers. Providers are also notified of updates and changes through website articles and through banner messages that are published in the weekly Remittance and Status (R&S) report. All of TMHP's bulletins, banner messages, and website articles are available on the TMHP website at www.tmhp.com.

Electronic Services

TMHP Website—The TMHP website at www.tmhp.com provides access to all Medicaid and CSHCN Services Program publications, forms, announcements of upcoming events, workshop schedules, fee schedules, and contact information for Provider Relations representatives. The website also offers electronic services through TexMedConnect.

TexMedConnect—TexMedConnect is TMHP's free, web-based application for claims filing, eligibility verification, claims status inquiry, Electronic Remittance and Status (ER&S) reports, eligibility verification, claims status inquiry, Electronic Remittance and Status (ER&S) reports, appeals, and more. TexMedConnect is available through the TMHP website at www.tmhp.com.

TMHP Online Provider Lookup—The Online Provider Lookup tool allows clients and providers to find information about Medicaid-enrolled providers. Medicaid providers can review and revise their demographic and contact information through the Online Provider Lookup tool on the TMHP website at www.tmhp.com. Providing specific details about practice limitations helps clients find exactly what they need.

Electronic Data Interchange (EDI)—Providers can use third-party software and billing agents to access the TMHP EDI Gateway. Contact the EDI Help Desk at 1-888-863-3638 for information about accessing electronic services using third-party software and billing agents.

Telephone Assistance

TMHP Contact Center—Texas Medicaid Program providers can call the TMHP Contact Center at 1-800-925-9126, Monday to Friday, from 7 a.m. to 7 p.m., Central Time, to speak with a TMHP Contact Center representative. Contact Center representatives answer questions about the Texas Medicaid Program and its guidelines, claims submission and prior authorization procedures, family planning, provider enrollment, ambulance authorization, and more.

TMHP-CSHCN Services Program Contact Center—CSHCN Services Program providers can call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, Monday to Friday, from 7 a.m. to 7 p.m., Central Time, to speak with a Contact Center representative. Contact Center representatives answer questions about the CSHCN Services Program and its guidelines, claims submission and prior authorization procedures, provider enrollment, and more.

Automated Inquiry System (AIS)—AIS is an automated response line that provides information about claims status, client eligibility, and other program-specific information. Medicaid and CSHCN Services Program providers can access AIS using the toll-free numbers below.

- Medicaid providers call: 1-800-925-9126
- CSHCN Services Program providers call: 1-800-568-2413

Workshops, Site Visits, and Individualized Assistance

Provider Relations—TMHP Provider Relations representatives are available to assist all providers with complex program issues, problem resolution, site visits, and training. Providers can find workshop schedules and contact information for the regional Provider Relations representatives on the TMHP website at www.tmhp.com or by calling the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

Once again, welcome and thank you for your dedication and commitment to improving the health of Texas families.

DCN: 20110203000847

JAN-20-2011 10:58 From:UTMB PROVIDERENROLLM 4097471023 To:TMHP P.1/7

utmb Health

Working together to work wonders.™

UTMB Physicians' Billing Services
123-25th Street, Shearn Moody Plaza, 2nd Floor
Galveston, TX 77555-1022

Facsimile Cover Letter

Date: 1/20/11 **Time:** **# of Pages Incl. Cover:** 7

To: TMHP

Phone: **Fax:** 512-514-4214

From: Jennifer Earnisse **Telephone:** 409-747-1063

Fax: 409-747-1023

RE: Lic Updt

COMMENTS: Regan N Theiler,MD TPI: 187728401

DCN: 20110203000847

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

P O Box 200795
Austin, TX 78720-0795
Fax 1-512-514-4214

January 9, 2011

REGAN N THEILER
PO BOX 4797-710
HOUSTON, TX 77210-4797

NPI 1609069558
TPI 18028401

NPI: 1609069558

Dear REGAN N THEILER

The Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment Department has reviewed your provider profile and our records indicate that your professional license number will expire on 02-28-2011.

To keep your record up to date and your transactions from being denied, you must provide your new license information to TMHP within 60 days from the date of this letter. The Texas Health and Human Services Commission (HHSC) has directed TMHP to place a payment denial code on providers who do not have a current professional license on file with TMHP. When a payment denial code is placed on your provider identifier, it results in the denial of your claims until the payment denial code is removed.

To have the payment denial code removed, please provide TMHP with a legible copy of your new license, along with your Texas Provider Identifier. Send this information to the following address or fax to 1-512-514-4214:

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

Thank you for your continued participation in Texas State Health-Care Programs. If you have any questions or need assistance, please call the TMHP Contact Center at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.

DCN: 20110203000847
JAN-20-2011 10:58 From:UTMB PROVIDERENROLLM 4097471023 To:TMHP P.3/7

Welcome to the TMB Website
Page 1 of 5

PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN

NAME: REGAN NELL THEILER MD **DATE:** 01/19/2011

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Date of Birth: 1973
License Number: M6911 - Physician License
Issuance Date: 06/08/2007
Expiration Date of Physician's Annual Registration Permit: 02/28/2013

Registration Status: ACTIVE
Disciplinary Status: NONE
Licensure Status: NONE

Registration Date: 08/28/2007
Disciplinary Date: NONE
Licensure Date: NONE

Medical School of Graduation:
At the time of licensure, TMB verified the physician's graduation from medical school as follows:
UNIV OF WISCONSIN MED SCH, MADISON

Medical School Graduation Year: 2003

TMB Actions and License Restrictions

The Texas Medical Board has taken the following board actions against this physician. (Also included are any formal complaints filed by TMB that are currently pending before the State Office of Administrative Hearings).

NONE

Investigations by TMB of Medical Malpractice

Section 164.201 of the Act requires that: the board review information relating to a physician against whom three or more malpractice claims have been reported within a five year period. Based on these reviews, the following investigations were conducted with the listed resolutions.

NONE

Status History

NPI
~~1660~~ 1609069558
TPI
187038401

DCN: 20110203000847

Welcome to the TMB Website Page 2 of 5

Status history contains entries for any updates to the individual's registration, licensure or disciplinary status types (beginning with 1/1/78, when the board's records were first automated). Entries are in reverse chronological order; new entries of each type supersede the previous entry of that same type. These records do not display status type. Should you have any questions, please contact our Customer Information Center at 512-305-7030 or verifcic@tmb.state.tx.us

Status Code: AC **Effective Date:** 06/28/2007
Description: ACTIVE

Status Code: LI **Effective Date:** 06/08/2007
Description: LICENSE ISSUED

THE INFORMATION IN THIS BOX WAS REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Gender: FEMALE
***Ethnicity:** WHITE
Race: WHITE
* We are in the process of transitioning from the current ethnic origin values to federal standards for race and Hispanic origin. The transition period will allow time for individuals to submit updated race and Hispanic origin data to the TMB.
Place of Birth: WISCONSIN
Primary Practice Address:
301 UNIVERSITY BLVD
UTMB DEPT OB/GYN
GALVESTON , TX 77555-0587

Years of Active Practice in the U.S. or Canada:
The physician reports that he/she has actively practiced medicine in the United States or Canada for 7 year(s).

Years of Active Practice in Texas:
The physician reports that, of the above years he/she has actively practiced in the State of Texas for 3 year(s).

Specialty Board Certification

The physician reports that he/she holds the following specialty certifications issued by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists:

Specialty Certification: AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY
Date: 2009

Primary Specialty

NPI 1669065558
TPI 187138401

Welcome to the TMB Website Page 3 of 5

The physician reports his/her primary practice is in the area of OBSTETRICS AND GYNECOLOGY.

Secondary Specialty
The physician did not report a secondary practice area.

Name, Location and Graduation Date of All Medical Schools Attended
Name: UNIVERSITY OF WISCONSIN-MADISON
Location: MADISON/WI/DANE
Graduation Date: 05/2003

Graduate Medical Education In The United States Or Canada
Program Name: EMORY UNIVERSISTY
Location: ATLANTA/GA **Begin Date:** 07/2003
Type: RESIDENCY **End Date:** 06/2007
Specialty: OBSTETRICS AND GYNECOLOGY

Hospital Privileges
The physician reports that he/she has hospital privileges in the following in the State of Texas:

Hospital: UTMB JOHN SEALY HOSPITAL
Location: GALVESTON, TX

Patient Services

Accessibility: The physician reports that the patient service area is accessible to persons with disabilities as defined by federal law.

Language Translation Services: The physician did not report whether he/she provided any language translation services for patients.

Medicaid Participant: The physician reports that he/she does participate in the Medicaid program.

Awards, Honors, Publications and Academic Appointments

Optional Information
The physician may optionally report descriptions of up to five such honors and has reported the following:

NONE

Hold NPI
1609069558
TPI
187738401

DCN: 20110203000847

JAN-20-2011 10:59 From:UTMB PROVIDERENROLLM 4097471023 To:TMHP P.6/7

Welcome to the TMB Website Page 4 of 5

Malpractice Information

Section 154.006(b)(16) of the Act requires that: a physician profile display a description of any medical malpractice claim against the physician, not including a description of any offers by the physician to settle the claim, for which the physician was found liable, a jury awarded monetary damages to the claimant, and the award has been determined to be final and not subject to further appeal. The physician has the following reportable claims.

Description: NONE

Criminal History

Self-Reported Criminal Offenses: The physician is required to report a description of (1) "any conviction for an offense constituting a felony, a Class A or Class B misdemeanor, or a Class C misdemeanor involving moral turpitude" and (2) "any charges reported to the board to which the physician has pleaded no contest, for which the physician is the subject of deferred adjudication or pretrial diversion, or in which sufficient facts of guilt were found and the matter was continued by a court of competent jurisdiction."

The physician has reported the following:

Description: NONE

Criminal history information is also obtained by TMB from the Texas Department of Public Safety. Resulting action, if any, will be reported under the TMB Action and Non-Disciplinary Restrictions section above.

Disciplinary Actions By Other State Medical Boards

The physician has reported the following:

Description: NONE

Physician Assistant Supervision

To obtain primary source verifications, click name

Description: NONE

Advanced Practice Nurse Delegation

To obtain primary source verifications, click name

Description: None

NPI 1609049559
TPI 137840

DCN: 20110203000847

Welcome to the TMB Website Page 5 of 5

NPI
1669106538
TPI
187128401

DCN: 20110893002302

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket #:	10799737
Date Printed:	Thursday, March 10, 2011
NPI:	1609069558
Provider Name:	THEILER , REGAN

1079737

DCN: 20110693000202

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

To enable HHSC to ensure compliance with statutory requirements about the use of Medicaid Women's Health Program funds, each Medicaid enrolled provider that renders services to Women's Health Program clients must complete this Certification and return the completed Certification to:

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

This Certification pertains to the following provider:

Provider Name **THEILER , REGAN**
Federal Tax ID Number
National Provider Identifier (NPI) Number **1609069558**

The provider is a:

- ☐ billing provider;
- ☐ performing provider; or
- ☐ both.

The Provider's billing address is:

Street Address **PO BOX 4797-710**
Street Address
City/State/Zip **HOUSTON, TX, 772104797**
Telephone Number

The provider's physical address is:

Street Address **301 University Blvd Ste 312**
Street Address
City/State/Zip **Galveston, TX, 775555302**
Telephone Number **4097722999**

(If the provider has additional physical addresses, please list them on a separate page.)

My name is **THEILER , REGAN** . I am the provider or, if the provider is not an individual or performing provider, I am the provider's . I am of sound mind, capable of making this Certification, and personally acquainted with the facts stated here. If I am representing the provider, I am authorized to make this Certification on the provider's behalf.

a. I affirm that the following statements are true and correct with respect to my or my organization's participation in the Medicaid Women's Health Program:

(1) The provider does not perform elective abortion[1] procedures.

(2) The provider will not perform elective abortion procedures within the span of effective dates listed below.

Provider Name **THEILER , REGAN**
NPI Number **1609069558**

(3) None of the funds the provider receives under the Medicaid Women's Health Program are used to pay for or provide direct support for elective abortion procedures.

(4) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay for or provide direct support for elective abortion procedures within the span of effective dates listed below.

(5) None of the funds the provider receives under the Medicaid Women's Health Program are used to pay costs associated with referring women for elective abortion procedures.

(6) None of the funds the provider receives under the Medicaid Women's Health Program will be used to pay costs associated with referring women for elective abortion procedures within the span of effective dates listed below.

(7) The services for which the provider currently bills the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).

(8) The services for which the provider will bill the Medicaid Women's Health Program are authorized services under Human Resources Code section 32.0248(a).

b. In addition, I understand and acknowledge that:

(1) If the provider fails to complete and submit this Certification or to update the information and representations made in this Certification as required in paragraph b (5) below, the provider will be ineligible to participate in the Medicaid Women's Health Program;

(2) If the provider has in the past or currently does any of the activities listed in Part a of this Certification, the provider may be ineligible to receive Medicaid Women's Health Program funds;

(3) If HHSC has reason to believe that the provider is ineligible to receive funds under the Medicaid Women's Health Program, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the billing provider until HHSC can make a final determination regarding the provider's eligibility;

(4) If HHSC determines that the provider is ineligible to receive funds under the Medicaid Women's Health Program:

(A) HHSC may recoup Medicaid Women's Health Program funds paid on claims incurred since the date the provider became ineligible;

(B) HHSC may place a payment hold on all Medicaid fee-for-service claims submitted by the provider; and

(C) the provider will not be eligible again to participate in the Medicaid Women's Health Program until it ceases every activity listed in Part a;

(5) the provider must notify HHSC at least 30 days prior to implementing any of the activities list in Part a of this Certification; and if the provider fails to do so, HHSC may place a payment hold on all Medicaid fee-for-service claims made by the provider; and

(6) any false statement or misrepresentation that I knowingly make on this Medicaid Women's Health Program Certification may constitute fraud or tampering with a government record under the laws of Texas and the United States and may lead

Please check the following statement:

☐ Yes, I affirm that the statements listed in Part a are true and correct.

Effective Date of Certification **3/10/2011** **through** **12/31/2011**

(The effective date of the Certification spans from the date of form completion through the end of the Certification year. Each provider must complete a new certification and mail it to TWHP by the end of each calendar year.)

☐ Terminate WHP Certification

Effective Date:

Signature _____

Printed Name _____

Title _____

DCN: 20110950004833

FMHP Florida Medicaid Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket # 10799737
Date Printed: Thursday, March 10, 2011
NPI 1609069558
Provider Name THELER , REGAN

[illegible] provider must notify MRSC at least 30 days prior to implementing any of the activities listed in Part A of this certification, and, if the provider is [illegible] by check is paid and filed on all Medicaid fee for service claims made by the provider, and

[illegible] any false statement or misrepresentation shall knowingly make on this Medicaid Provider Agreement or upon claims made against it pursuant thereto is guilty of a [illegible] punishable in jail for the term of years and the amount stated in the bond

[illegible] the following statement

I [illegible] that the statements listed in Part A are true and correct

Effective Date of Certification: 3/10/2011 through 12/31/2011

[illegible] effective date of the Certification spans from the date of form completion through the end of the Certification year. Each provider must [illegible] by the end of each calendar year.)

[illegible] date Certified on:

Signature: Regan N Theiler, MD

Title: Assistant Professor

* For purposes of this Certification, the term "elective abortion" excludes those abortions defined by Williams Obstetrics, 22nd Ed. (2005), the American College of Obstetricians and Gynecologists (1997) and Tex. Health & Safety Code §171.002(3)(A) to include: (1) terminations of pregnancy that resulted from an act of rape or incest, (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy that she would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or (3) when the fetus has a severe or severe irreversible anomaly that is likely to result in death of the fetus upon birth or shortly thereafter or severe physical deformities that would require heroic and extensive efforts to support life after birth.

MR08

[illegible]

DCN: 201109500004933

MEDICAID WOMEN'S HEALTH PROGRAM CERTIFICATION

[illegible] Medicaid Women's Health Program [illegible] complete this Certification and return the completed Certification to:

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

[illegible] pertains to the following provider:

[illegible] Name THEILER , REGAN

Federal Tax ID Number

[illegible] Number 1609069558

[illegible]

[illegible] billing provider

[illegible] performing provider [illegible]

[illegible]

[illegible] billing address is:

Street Address PO BOX 4797-710

Street Address

City/State/Zip HOUSTON, TX, 772104797

Telephone Number

[illegible] physical address is:

Street Address 301 University Blvd Ste 312

Street Address

City/State/Zip Galveston, TX, 775555302

Telephone Number 4097722999

[illegible] additional physical addresses, please list them on a separate page.)

My name is THEILER , REGAN. I am the provider [illegible] authorized to make this Certification [illegible]

[illegible] I affirm that the following statements are true and correct with regard to [illegible] Medicaid Women's Health Program:

(1) The provider does not perform elective abortion[1] procedures.

(2) The provider will not perform elective abortion procedures within the span of effective dates listed below.

Provider Name THEILER , REGAN

[illegible] Number 1609069558

(3) [illegible]

(4) [illegible] within the span of effective dates listed below.

(5) [illegible]

(6) None of the funds the provider receives under the Medicaid Women's Health Program [illegible] within the span of effective dates listed below.

(7) The services for which the provider currently bills the Medicaid Women's Health Program [illegible]

(8) The services for which the provider will bill the Medicaid Women's Health Program are [illegible] Human Resources Code Section [illegible]

[illegible] I understand and acknowledge that:

(1) If the provider fails to complete and submit this Certification or to update the information [illegible] the provider will be ineligible to participate in the Medicaid Women's Health Program.

(2) [illegible] Health Program funds.

[illegible]

(3) [illegible]

(a) [illegible]

(b) [illegible]

(c) [illegible]

[illegible]

DCN: 20110650004833

FOR UPS SHIPPING ONLY

Page 1 of 1

From:
UTMB
Veronica Ayala
Shearn Moody Plaza
123 25th St, 2nd Floor
Galveston, TX
77550
409-772-0848

Airbill No. ESG77380

1800-800-8984

To:
TMHP

12357B Riata Trace Pkwy
Austin, TX 78727
512-506-7072

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0 x 0 x 0

Printed
04/04/2011
Ref:
Pieces: 1 /1

AUS

PRIORITY

131500