Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket #: 11353372
Date Printed: Thursday, April 19, 2012
NPI: 1649331497
Provider Name: Fine, Paul

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: Privacy Statement

Privacy Statement

With a few exceptions, Texas privacy laws and the Public Information Act entitle you to ask about the information collected on this form, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the Texas Administrative Code, sections 351.17 through 351.23.

For questions concerning this notice or to request information or corrections, please contact Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126.

I Disagree

I do not agree with the above privacy statement and wish to return to the TMHP web site.

I Agree

I have read and understand the above privacy statement and wish to proceed to the provider enrollment web site.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: Introductions and Provider Agreement

Introductions and Provider Agreement

Dear Health-care Professional:

Thank you for your interest in becoming a Texas State Health-Care Programs provider. Participation by providers in Texas State Health-Care Programs is vital to the successful delivery of healthcare services, and we welcome your application for enrollment.

As a potential new provider to Texas State Health-Care Programs, you must follow certain claims filing procedures while completing the enrollment process. *This is particularly important if you render services to clients before you are enrolled.*

To access the Texas Medicaid Provider Procedures Manual and Children with Special Health Care Needs (CSHCN) Services Program Provider Manual, visit **www.tmhp.com** and select "Find Publications/File Library" under the "I would like to..." menu on the right-hand side of the page. Select "Provider Manuals" from the menu to view the provider manuals.

There is no guarantee your application will be approved for processing or you will be assigned a Texas Provider Identifier (TPI) number. If you make the decision to provide services to a Texas State Health-Care Programs 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 Texas State Health-Care Programs and the law also prohibits you from billing the Texas State Health-Care Programs client for services rendered.

Important Information – Please Read

When medical services are rendered to a Medicaid client in Texas, TMHP must receive claims within 95 days of the DOS on the claim.

- Claims submitted by newly enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the DOS.
- TMHP must receive claims on behalf of an individual who has applied for Medicaid coverage but has not been assigned a Medicaid number on the DOS within 95 days from the date the eligibility was added to the TMHP eligibility file (add date) and within 365 days of the date of service or from the discharge date for inpatient claims.
  * If a client becomes retroactively eligible or loses Medicaid eligibility and is later determined to be eligible, the 95-day filing deadline begins on the date that the eligibility start date was added to TMHP files (the add date). However, the 365-day federal filing deadline must still be met.
- When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP must receive Medicaid claims within 95 days of the date of Medicare disposition.
- When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and subject to the 95-day filing deadline (from date of discharge).
- TMHP must receive claims from out-of-state providers within 365 days from the DOS. The DOS is the date the service is provided or performed.

TMHP must receive all CSHCN Services Program claims within the required filing deadlines regardless of enrollment status. Claims filed while waiting to receive a provider identifier are denied. However, after a provider identifier (TPI) is assigned, the provider can resubmit or appeal the claims that were denied while waiting for confirmation of enrollment. The resubmitted claim will be considered for payment if received by TMHP within 120 days of the denial date. Inpatient claims filed by a hospital must be submitted to TMHP within 95 days of the discharge date. Hospitals may submit interim claims prior to discharge, which must be submitted to TMHP within 95 days of the last date of service on the claim. Outpatient hospital services must be submitted to TMHP within 95 days of the date of service. All other claims must be submitted to TMHP within 95 days of each date of service.

The Texas Medicaid Provider Procedures Manual and the Children with Special Health Care Needs (CSHCN) Services Program Provider Manual contains important information about provider responsibilities, filing deadlines and procedures, and much more. It is also available for you to download at **www.tmhp.com** or you may call **1-800-925-9126** to request a printed copy.

For information about TPI requirements, the status of your enrollment, or claims submission, call **TMHP Contact Center toll-free at 1-800-925-9126 or the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.** TMHP customer service representatives are available Monday through Friday from 7 a.m. to 7 p.m. central standard time.

Thank you for your applying to become a Texas State Health-Care Programs provider.

Sincerely,
Ira Bell, III, M.D., M.B.A.
TMHP Chief Medical Officer

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Initial Checklist

Print Checklist

In order to move through this application efficiently please prepare with these three important steps:

1. **Prepare**

   The application will take approximately 30 minutes to complete. Gather the following pieces of information to complete your application:

   - National Provider Identifier (NPI)
   - Primary Taxonomy Code
   - Texas Provider Identifier (TPI) (if applicable)
   - Professional license information (professional licensing board, professional license number, state, etc.) All licensure must be current and not expired within 30 days.
   - Social Security Number
   - Employer's Tax Identification Number
   - Medicare intermediary, certification number (if applicable) and effective date
   - Driver's license number and expiration date
   - CLIA certification information (number and physical address)
   - Texas Education Association (TEA) Number (if applicable)
   - Electronic funds information (bank name, phone number, address, ABA/Transit number, account number, etc.)

2. **Complete**

   - Any fields marked with a red dot are required.
   - Any addresses listed on the application will be validated against United States Postal Service (USPS) records to confirm the address is valid and conforms to USPS standards.
   - By clicking "Continue and Save" you will be taken to the next page of the application and the data entered on the previous screen will be saved.
   - The application will time out after 30 minutes if no action is taken.
   - If you are unable to complete the application in one session, you can click "Continue and Save" and log off.
   - By clicking "Save as Template" you will be able to create a template of your application that you will be able to reuse for multiple enrollments.
   - To continue a previously saved application or if you received a timeout error:
     - Log into the Provider Enrollment portion of www.tmhp.com
     - Click View Existing Transactions.
     - Click on the Portal Ticket number to open and continue the application.

3. **Review**

   - Review the final checklist available on the Application Submitted screen.
   - Print confirmation letter and required documentation.
   - **Note the Portal Ticket number.**
   - All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested. Submit a cover letter listing the contact address and phone number to have deficiency letters mailed elsewhere.
   - Mail in the confirmation letter, signed agreements, and the required additional documentation to the following address:

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

     Physical Address:
     Texas Medicaid & Healthcare Partnership
     ATTN: Provider Enrollment
     12357-B Riata Trace Pkwy.
     Austin, TX 78727

4. **Out of State Providers**

   Send proof of meeting one of the following criteria:

   - 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.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: Useful Information – Please Read

Claims Filing Information

When a service is a benefit of Medicare and Medicaid, and the client is covered by both programs, the claim must be filed with Medicare first. TMHP only processes one client per Medicare RA. For multiple clients, submit one copy per client. TMHP must receive Medicaid claims within 95 days from the date of Medicare disposition. Providers submit the Medicare Remittance Advice Notice (MRAN) with the client's Medicaid number to TMHP. When a client is eligible for Medicare Part B only, the inpatient hospital claim for services covered as Medicaid only is sent directly to TMHP and subject to the 95-day filing deadline (from date of discharge).

All claims for services rendered to Medicaid clients who do not have Medicare benefits are subject to a filing deadline from date of service of:

- 95 days of the date of service on the claim, or within 95 days from the date a new provider identifier is issued for instate providers and providers located within 50 miles of the Texas state border
- 365 days for OUT-OF-STATE providers or from the discharge date for inpatient claims

The Texas Health and Human Services Commission (HHSC) established these deadlines.

Therefore, providers must submit all claims for services that have been provided to Medicaid clients to the following address within the 95-day filing deadline.
Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal. Procedures for appealing denied or rejected claims are included on the Remittance and Status (R&S) report and in the *Texas Medicaid Provider Procedures Manual*.

TMHP must receive all CSHCN Services Program claims within the required filing deadlines regardless of enrollment status. Claims filed while waiting to receive a provider identifier are denied. However, after a provider identifier (TPI) is assigned, the provider can resubmit or appeal the claims that were denied while waiting for confirmation of enrollment. The resubmitted claim will be considered for payment if received by TMHP within 120 days of the denial date.

Inpatient CSHCN Services Program claims filed by a hospital must be submitted to TMHP within 95 days of the discharge date. Hospitals may submit interim claims prior to discharge, which must be submitted to TMHP within 95 days of the last date of service on the claim. Outpatient hospital services must be submitted to TMHP within 95 days of the date of service. All other CSHCN Services Program claims must be submitted to TMHP within 95 days of each date of service. Procedures for appealing denied or rejected claims are included on the Remittance and Status (R&S) report and in the *Children with Special Health Care Needs (CSHCN) Services Program Provider Procedures Manual*.

Limited ("Lock-In") Information

Clients are placed in the Limited Program if, on review by HHSC and the Office of Inspector General (OIG), their use of Medicaid services shows duplicative, excessive, contraindicated, or conflicting health care services and/or drugs; or if the review indicates abuse, misuse, or fraudulent actions related to Medicaid benefits and services. Clients qualifying for limited primary care provider status are required to choose a primary care provider. The provider can be a doctor, clinic, or nurse practitioner in the State Healthcare Programs. If a limited candidate does not choose an appropriate care provider, one is chosen for the client by HHSC/OIG after obtaining an agreement from the provider. The provider is responsible for determining appropriate medical services and the frequency of such services. A referral by the primary care provider is required if the client is treated by other providers.

Change of Ownership (CHOW)

Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and HHSC, a change in ownership of a facility does not terminate Medicare eligibility. Therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements:

1. Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
2. Complete new State Healthcare Programs provider enrollment packet.
3. Provide TMHP with copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners).
4. Give a listing of ALL provider numbers/TPIs affected by the change in ownership.

Communication Information

Enrollment Applications:

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

Physical Address:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
12357-B Riata Trace Pkwy.
Austin, TX 78727

Claims:

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Comprehensive Care Program (CCP) Provider Customer Service..... 1-800-846-7470

Medicaid Provider Helpline	1-800-925-9126
TMHP Electronic Data Interchange (EDI) Help Desk	1-888-863-3638

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Programs

Delivery Notification
You will be notified of application deficiencies by e-mail unless you choose to receive the paper notification by mail. Choosing to opt out of receiving a notification will increase your overall processing time on your application. TMHP strongly encourages you to receive enrollment notifications via email.

☐ I wish to receive my deficiency notifications by mail

Application Type Identification

Please select all the programs you would like to enroll in:

☐ Traditional Medicaid	
☐ THSteps Medical	For more information about the Texas Health Steps Medical program, click here.
☐ CSHCN Services Program	For more information about the Children with Special Health Care Needs (CSHCN) Services Program, click here.
☐ THSteps Dental	For more information about the Texas Health Steps Dental (Oral Health) program, click here.
☐ Medical Transportation Program (MTP)	

EXPLANATION OF PREREQUISITES TO ENROLL WITH THSteps Medical:

- Applicant must be currently enrolled in the Texas Medicaid Program
- Please refer to your Texas Medicaid Provider Procedures Manual to verify specific conditions for each provider type.

The following provider types can enroll into THSteps using this form:

- Physicians
- Family and Pediatric Nurse Practitioners
- Certified Nurse Midwives enrolled as providers of THSteps medical checkups for newborns younger than 2 months of age and adolescent females.
- Women's health care nurse practitioners enrolled as providers of THSteps medical checkups for adolescent females
- Adult nurse practitioners enrolled as providers of THSteps checkups for adolescents
- Health care providers or facilities (public or private) capable of performing the required medical checkup procedures under a physician's direction.

A new enrollment application must be completed and a new provider identifier must be issued when one of the following changes:

- Medicare Number-If Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location or with a new group.
- Ownership-The new owner must do the following
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership
  - Complete the Texas Medicaid Provider Enrollment Application
  - Provide TMHP with a copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners)
  - Provide a listing of all of the provider identifiers affected by the change of ownership
- Provider Status (individual, group, performing provider, or facility)-Providers leaving group practices must send a signed letter on company letterhead to TMHP that states the date of termination. The letter should include the provider identifier, effective date of termination, and the group's provider identifier. The letter should be signed by an authorized representative of the group or the individual provider leaving the group. If the provider is joining a new group practice or enrolling as an individual, the provider must complete and submit a Texas Medicaid Provider Enrollment Application to request enrollment in the new group or as an individual provider.
- Physical Address-If a provider is changing an address, and the address is within the Medicare locality, the provider must complete and submit a Provider Information Change (PIC) Form. A W9 is required if the provider is changing the mailing address. If the address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.
- Provider Type-Providers must submit a separate Texas Medicaid Provider Enrollment Application for each provider type enrollment requested.

NOTE: Texas Health Steps providers must enroll in Texas Vaccines for Children's Programs to receive free vaccines. Applications may be downloaded at http://www.dshs.state.tx.us/immunize/forms/6-102.pdf or you may call 1 (800) 252-9152 for more information. Medicaid does not reimburse for vaccines that are available from VFC.

EXPLANATION OF REQUIRED ATTACHMENTS FOR ENROLLMENT USING THIS FORM:

- A current IRS W-9 form must be submitted with your completed Enrollment into Texas Health Steps
- Copy of current license and/or any appropriate certifications that does not expire within 30 days
- Approval letter must be attached if required for the program in which you are seeking enrollment
- Provider Information Form (PIF-1) for the provider seeking enrollment into an additional program if the Texas Medicaid Provider Enrollment Application was completed more than 12 months ago
- Principal Information Form (PIF-2) for all owners and principals parties if the Texas Medicaid Provider Enrollment Application was completed more than 12 months ago
- Disclosure of Ownership if the Texas Medicaid Provider Enrollment Application was completed more than 12 months ago.

DISCLAIMER:

- The signature provided on page three of the Enrollment into Texas Health Steps must be signed by the person who is seeking enrollment into an additional program.
  - The provider's signature is required on the attached document for any/all enrollment requests for individual practitioner provider numbers.
  - Signatures by the authorized representative of a group or facility only is acceptable for enrollment requests for group/facility provider numbers
- By signing page three of the Application for Enrollment into Texas Health Steps, the provider is agreeing to an extension of the terms included in the Provider Agreement for the provider number listed on page three

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Programs: Provider Type Identification Form

Provider Type Identification

Are you using a Medicare certification number for this enrollment? Yes No To access the Medicare Number Required Provider List Click here.

Do not continue with this application if your Medicare certification number is pending. Once you have received a Medicare certification number, you may submit an online application for enrollment into Texas State Health-Care Programs. Your enrollment effective date will be retroactive to your Medicare certification date. Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service.

If you are one of the following provider types that is eligible for a Medicare waiver, you may continue with the online application: Audiologist, Dentist (D.D.S., D.M.D.), Nurse Practitioner/Clinical Nurse Specialist (NP/CNS), Optometrist (OD), Orthotist, Physician (DO), Physician (MD), Physician Assistant, Prosthetist.

If you are not one of these types of providers and your provider type is enabled in the Traditional Services box below, you may continue with the online application without a Medicare waiver.

If the provider type you wish to enroll as is not available for selection in the Traditional Services box below, you must submit a paper application for enrollment into Texas State Health-Care Programs.

Applicant is enrolling as: Individual Performing Provider Group Facility

And as a: Single Specialty Multi-Specialty

NPI/API:
Please click Verify NPI to validate the NPI you are enrolling against NPPES data.
1649331497

If you do not have an NPI, choose a provider type:
If the appropriate Provider Type is not available, you are not eligible to enroll as an A-Typical Provider.
- select -

Traditional Services

- 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 (Physician Involvement)
- Independent Lab (No Physician Involvement)
- Indian Health Services (IHS)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Maternity Service Clinic (MSC)
- Mental Retardation Diagnostic Evaluation (MRDE)
- Medical Transportation Program (MTP)
- Milk Bank Donor
- Multi-Specialty Group
- Nurse Practitioner/Clinical Nurse Specialist
- Occupational Therapist (OT)
- Optician
- Optometrist (OD)
- Orthotist
- Outpatient Rehabilitation Facility (ORF)
- Personal Assistant Services
- Pharmacist
- Pharmacy Group
- Physical Therapist (PT)
- Physician (DO) OB/GYN and Pediatricians not required to have a Medicare Number
- Physician (MD) OB/GYN and Pediatricians not required to have a Medicare Number
- Physician Assistant
- Physiological Lab
- Podiatrist
- Portable X-Ray
- Prosthetist
- Prosthetist-Orthotist (Choose if licensed as both)
- Psychologist
- Qualified Rehabilitation Professional
- Radiation Treatment Center
- Radiological Lab
- Renal Dialysis Facility
- Respiratory Care Practitioner
- Rural Health Clinic – Hospital, Freestanding
- Skilled Nursing Facility
- Specialized/Custom Wheeled Mobility – CCP(under 21)
- Specialized/Custom Wheeled Mobility – Home Health(all ages)
- Social Worker (LCSW)
- SHARS — School, Co-op or School District
- SHARS — Non-School
- Service Responsibility Option (SRO)
- TB Clinic
- Vision Medical Supplier (VMS)

I certify my practice is limited to individuals' birth through 20 years of age. I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers

☐ cannot request a Medicare Waiver when joining a group that is Medicare enrolled. **A signed Explanation / Justification letter on company letterhead must be submitted to TMHP with submission of this application's signature page for consideration of the Medicare Waiver Request.**

☐ I certify that the service(s) I render is/are not recognized by Medicare for reimbursement. I further certify the claims for these services will not be billed to Medicare (this includes Medicare crossover claims). I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled. **A signed Explanation / Justification letter on company letterhead must be submitted to TMHP with submission of this application's signature page for consideration of the Medicare Waiver Request.**

Case Management Services

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

Comprehensive Care Services (CCP)

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

Texas Health Steps Medical(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 State of Texas?**
(If "no", please answer the next question.)
○ Yes ◉ No

Does your clinic/practice provide routine recommended vaccines to children ages 0 to 18 years?
If yes, click here to access the TVFC form.
○ Yes ◉ No

I understand that this is the last time I can edit this page: ☒

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Programs: Provider Type Specific

Name of Provider Enrolling:

* Group / Company or Last Name:	Fine
First Name:	Paul
Middle Initial:	M
* Are you a private or public entity?	(•) Private ( ) Public

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Programs: Provider Specialty/Taxonomy

You are required to complete this screen for every provider type that you are enrolling per Enrollment guidelines.

Program: Traditional Medicaid

Services: Physician (MD)
OB/GYN and Pediatricians not required to have a Medicare Number

Please select your taxonomies

TMHP has reviewed and assigned all taxonomy codes that reflect services that are a benefit of the Texas State Programs. The taxonomy codes that are listed are specific to the services rendered by the provider type and specialty that you have chosen.

If you are enrolling as a group you will be asked to assign a taxonomy code for the group TPI and each of the performing providers in the group. The group TPI will have the taxonomy code that describes either a multi specialty or single specialty group. The performing provider will have a choice of taxonomy codes specific to the services rendered for the provider.

Group TPI: **082006001**

Primary Specialty: **OB/GYN (MD)**

Sub-Specialty: (If applicable)

Available Codes:

Click here to view Taxonomy definitions from the Washington Publishing Company.

*** Primary Taxonomy Code:**
207VG0400X

Secondary Taxonomy Codes:
(Maximum 15 codes allowed)

Enter Texas Non-Enrolled Taxonomy Code:

All letters in taxonomies must be capitalized.

This button will enable after clicking "Retrieve Taxonomies" above.

Texas Non-Enrolled Taxonomy Codes:
(Maximum of 5 Codes Allowed)

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Medicaid Programs: Provider Demographics

Existing Medicaid Texas Provider Identifiers (TPIs):
(Please list all other assigned Texas Medicaid TPIs)

Existing TPIs

* Do you want to be a limited provider? ○ Yes ◉ No

Group/ Company or Last Name: Fine

First Name: Paul

Middle Initial: M

* Title / Degree: MD

D.B.A:

* Social Security Number:

* Date of Birth:

Provider Business Email:

Provider Business Web Site Address:

Physical Address:
(Where services are rendered)

* Street: 1504 Taub Loop

Suite:

* City: Houston

* State: Texas

* ZIP Code: 770301608

☐ Same as physical address

Accounting / Billing Address:
(Where provider information is to be sent)

Street: PO BOX 4780

Suite:

City: Houston

State: Texas

ZIP Code: 772104780

* Phone Number: 7137981835 ext.

Fax Number:

Business Fax Number:

* Select a reason for applying to join Texas State Health-Care Programs: Adding performing provider to an existing group

Supervising or Referring/Consulting Physician

License Number:

License Issue Date: mm/dd/yyyy

License Expiration Date: mm/dd/yyyy

* Professional Licensing State: Texas

* Professional Licensing Board: Texas Medical Board

* Professional License Number: E7917

* Professional License Issue Date: 6/14/1977

* Professional License Expiration Date: 2/28/2013

* Medicare Intermediary: TrailBlazer Health Enterprises, LLC

* Medicare Number: TXB134223

* Medicare Certification Date: 7/1/2011

Groups participating in Medicare must have a current Medicare number before enrolling with the Texas Medicaid Program. A valid and current Medicare number must be maintained. Performing providers of a Medicare group must also have a current Medicare number before enrolling in the Texas Medicaid Program.

* Legal Name According to the I.R.S.: (Identical to W-9) Baylor College of Medicine

* Employer's Tax I.D. Number: 741613878

* Accepting New Clients? ◉ Yes ○ No

* Gender Limitations: Both

0

* Counties Served: Harris

For Provider Records Only - Not to be sent to TMHP

Portal Ticket # 11353372

Client Age Restrictions:	TO 105

* Will you perform Women's Health Program services? Yes No

By selecting "Yes" and completing the Medicaid Women's Health Program (WHP) Certification Form you are attesting that you will not perform or promote elective abortion or affiliate with another entity that performs or promotes elective abortions during the period of certification. For more information about the Women's Health Program, visit the Texas Medicaid Provider Procedures Manual by **clicking here**.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment : Application for Texas State Programs: Provider Information Form (PIF-1)

Instructions

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 Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types.

The Provider or a duly authorized representative of the Provider 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:

- provide medical assistance, Medicaid, under contract or provider agreement with the Commission or its designee; or
- 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.

Group/ Company or Last Name:	**Fine**
First Name:	**Paul**
Middle Initial:	**M**
Title/Degree:	**MD**
National Provider Identifier (10 digit):	**1649331497**
Maiden Name:	
Other Alias or Nicknames ever used:	

Physical Address:		Accounting/ Billing Address:	
Street:	**1504 Taub Loop**	Street:	**PO BOX 4780**
Suite:		Suite:	
City:	**Houston**	City:	**Houston**
State:	**Texas**	State:	**Texas**
ZIP Code:	**770301608**	ZIP Code:	**772104780**

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 (Specify)

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: Provider Information Form (PIF-1) Continued

Professional Licensing Board:	Texas Medical Board	Professional License Number:	E7917
State Issuer:	Texas		
Professional License Initial Issue Date:	6/14/1977	Professional License Current Expiration Date:	2/28/2013
Social Security Number:		Employer's Tax ID:	741613878
Specialty of Practice: (Example: Pediatrics, General Practice, etc)	OB/GYN (MD)	Medicare Provider Number:	TXB134223
Medicare Intermediary:	TrailBlazer Health Enterprises, LLC	Medicare Effective Date:	7/1/2011

* Driver's License or Other Number:
* Driver's License or Other Expiration Date:
* State Issuer:
* Date of Birth:
* Gender: Male Female

CLIA Number:
(Send a copy of the CLIA certification)

CLIA Address:
(Enter the address listed on the CLIA certification)

Street:
Suite:
City:
State:
ZIP Code:

RESNA and NRRTS Certification Information:

RESNA Certification Number:
RESNA Certification Issue Date: mm/dd/yyyy
RESNA Certification Expiration Date: mm/dd/yyyy

NRRTS Certification Number:
NRRTS Certification Issue Date: mm/dd/yyyy
NRRTS Certification Expiration Date: mm/dd/yyyy

Previous Physical Address

Street:
Suite:
City:
State:
ZIP Code:

Same as previous physical address

Previous Account / Billing Address

Street:
Suite:
City:
State:
ZIP Code:

* **Do you plan to use a Third Party Biller to submit your Medicaid claims?** Yes No

If yes, provide the following information about the billing agent:

Billing Agent Name:
Tax ID Number:
Contact Person Name:
Telephone Number: Ext.

Street Address:
Suite:
City:
State:

For Provider Records Only - Not to be sent to TMHP

Portal Packet # 1135372

ZIP Code:

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/Atypical Provider Identifier (API) or TPI of each Provider or entity:

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contact 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.

* Is your professional license or certification currently revoked, suspended or otherwise restricted? Yes No
* Have you ever had your professional license or certification revoked, suspended, or otherwise restricted? Yes No
* Are you currently or have you ever been subject to a licensing or certification board order? Yes No
* Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action? Yes No

If yes was answered to any of the questions, fully explain the details including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license:

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: Provider Information Form (PIF-1) Continued

*** 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 a criminal history check.)

Convicted means that:

(a) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

- There is a post-trial motion or an appeal pending, or
- The judgement 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, provide the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:

* Are you currently behind 30 days or more on court ordered child support payments?

○ Yes ○ No

If yes, fully explain the details, including date, the state and county where the incident occurred, the cause number(s), and specifically what you were convicted of:

* Country of Citizenship

United States

If you did not answer "United States of America" above, send a copy of your green card, visa or other documentation demonstrating your right to reside and work in the United States.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment: Application for Texas State Programs: CSHCN Services Program Identification Form

Instructions All provider types must be enrolled with the Texas Medicaid Program as a prerequisite to enrolling in the CSHCN Services Program.

Call the TMHP contact center at 1-800-568-2413 for infomation about the CSHCN Services Program and provider enrollment criteria.

Step 1: Please select a service

You selected **Physician Services (M.D.)/Multi-Specialty Group.**

Step 2: Please select your taxonomies

TMHP has reviewed and assigned all taxonomy codes that reflects services that are a benefit to the Texas State Programs. The taxonomy codes that are listed are specific to the services rendered by the provider type and specialty that you have chosen.

If you are enrolling as a group you will be asked to assign a taxonomy code for the group TPI and each of the performing providers in the group. The group TPI will have the taxonomy code that describes either a multi specialty or single specialty group. The performing provider will have a choice of taxonomy codes specific to the services rendered for the provider.

Group TPI **082006008**

* Primary Specialty: **OB/GYN (MD)**

Sub-Specialty: (If applicable)

Available Codes:

Click here to view Taxonomy definitions from the Washington Publishing Company.

*** Primary Taxonomy Code:**
207VG0400X

Secondary Taxonomy Codes:
(Maximum of 15 Codes Allowed)

Texas Non-Enrolled Taxonomy Code:

This button will enable after clicking "Retrieve Taxonomies" above.

Texas Non-Enrolled Taxonomy Codes:
(Maximum of 5 Codes Allowed)

All letters in taxonomies must be capitalized.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Enrollment Application for Texas State Programs

SECTION C: Group Practice (Required if enrolling as a GROUP PRACTICE)

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

(•) Adding additional performing provider(s) to an existing group

If this is a new application for group enrollment, list all providers associated with the group that are applying for enrollment at the same time as the group. If the group is already enrolled, list only the providers to be added to the group.

Group Medicare Number: (If applicable) **00D19V**

Group PEP Ticket Number:

Up to 50 performing providers can be added with a group application. If the group has more than 50 performing providers, the remainder must be added on a separate PEP application that references the Portal Ticket Number of the group application for the group.

Notification of your assigned TPI will be mailed to the Physical address listed on your application. All correspondence related to this application (i.e. enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

HHSC Medicaid Provider Agreement (Traditional Medicaid)

Name of Provider

Last Name:	Fine	TPI Number:	
First Name:	Paul	Medicare Provider ID Number:	TXB134223
Middle Initial:	M		

Physical Address		Accounting/Billing Address (if applicable)	
Street	1504 Taub Loop	Street	PO BOX 4780
Suite		Suite	
City	Houston	City	Houston
State	TX	State	TX
ZIP Code	770301608	ZIP Code	772104780

Please read the agreement below and check "I Agree."

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.

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 its 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).

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

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.

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.

•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 checking below, Provider acknowledges and certifies to all of the following:

•Provider must notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy and must copy TMHP and HHSC with all the Provider's pleading in the case. A failure to notify TMHP and HHSC of a bankruptcy petition is a material breach of the Provider Agreement.

•Provider has screened all employees and contractors to determine whether any of them have been excluded before and after enrollment.

•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.

The applicant must sign the agreement if enrolling as an individual.

I agree to the terms and conditions above: ☐

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program

Legal name of Provider/ Facility:	**Baylor College of Medicine**	Medicaid TPI:	
Last Name:	**Fine**	CSHCN Services Program TPI:	
First Name:	**Paul**		
Middle Initial:	**M**		
Physical Address			
Street	**1504 Taub Loop**		
Suite			
City	**Houston**		
State	**TX**		
ZIP Code	**770301608**		

Please read the agreement below and check "I Agree."

The provider agrees, in accordance with the state laws, rules and regulations pertaining to DSHS, CSHCN Services Program, and as a condition for participation in this program, to the terms and conditions set forth below:

1. A copy of the current CSHCN Services Program Provider Manual has been or will be furnished to the Provider. The provider manual, all revisions made to the provider manual through quarterly CSHCN Services Program provider bulletins, and written notices are incorporated into this Agreement by reference. The CSHCN Services Program 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 1-800-568-2413. Provider has a duty to become familiar with the contents and procedures contained in the provider manual. Provider agrees to comply with all the requirements of the provider manual, as well as all state and federal laws and amendments, governing or regulating CSHCN Services Program. 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 and federal laws and amendments governing or regulating CSHCN Services Program.

2. To maintain and retain for a period of five years from the date of service, or until audit and all audit exceptions are resolved, whichever period is longer, such records as are necessary to fully disclose the extent of the services provided to the clients receiving assistance under the CSHCN Services Program and any information relating to payments claimed by the Provider. Providers must cooperate and assist DSHS or its designee, the Texas Health and Human Services Commission (HHSC), Office of Inspector General, 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 designees access to its premises as required by Title 1 Texas Administrative Code (TAC) §1643. If litigation is involved, the records must be retained until litigation is ended or for five (5) years as cited above, whichever is longer.

3. To provide unconditionally, upon request, free copies of and access to all records pertaining to the services for which claims are submitted to CSHCN Services Program or its designees.

4. To accept CSHCN Services Program payment as payment in full for service. Provider may collect allowable insurance or health maintenance organization co-payments in accordance with those plan provisions.

5. Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes and provide such information, on request, to HHSC, DSHS, Office of the Inspector General, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the CSHCN Services Program current by informing DSHS or its designee 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 DSHS or its designee 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 submit to DSHS complete information related to any such suspension or restriction. Provider agrees to disclose all convictions of Provider and 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 Title 42, Code of Federal Regulations (CFR) §1001.2. All principals of the Provider include an owner with a direct or indirect ownership or control interest of 5% or more, is an agent or managing employee of the Provider, is a corporate officer or director, general or limited partner, agent, managing employee (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof.

6. The Office of Inspector General, internal and external auditors for the state/federal government, DSHS and/or HHSC may conduct interviews of the 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 the 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 with in 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 Office of Inspector General. Subcontractors are those persons or entities that provide medical goods or services for which the Provider bills the CSHCN Services Program or who provide billing, administrative, or management services in connection with CSHCN Services Program covered services.

7. Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by DSHS and HHSC, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims 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, Providers understand that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

8. To accept payments established by the Texas Medicaid Program as payment in full for Medicaid covered services for those clients who are assisted by this resource.

9. To utilize CSHCN Services Program as a resource for payment when clients are eligible for program assistance.

10. Provider acknowledges that it/they have executed an HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts. All of the provisions of the HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts are hereby incorporated by reference in this Provider Agreement with the Department of State Health Services (DSHS) for participation in the Children with Special Health Care Needs (CSHCN) Services Program.

11. To utilize Texas Medicaid, Children's Health Insurance Program (CHIP), and/or private insurance (including HMO coverage) and the United States Department of Defense or Department of Veterans Affairs benefit plans as sources for reimbursement because they are primary to CSHCN Services Program payments.

12. To not bill the client/family for the cost of any charges not paid for by CSHCN Services Program due to the provider's failure to request the required authorization and/or failure to

submit a claim for reimbursement within the appropriate submission deadline.

13. To not charge the client/family any pre-admission or pretreatment charges or deposits if services are reimbursable by CSHCN Services Program.

14. To refund the client/family any pre-admission or pretreatment charges when services are authorized and collection occurred prior to program application and eligibility determination.

15. To request authorization from CSHCN Services Program, before the date of service, for all services requiring prior authorization.

16. To request authorization from CSHCN Services Program for all services requiring authorization before the date of service or up to 95 days after the date of service.

17. That claims submitted by me, or on my behalf, for payment by the CSHCN Services Program shall be for services or items actually provided by me or under my personal supervision to the eligible recipient identified as the client for which I am entitled to payment. Claims must be submitted in the manner and in the form set forth in the CSHCN Services Program Provider Manual and within the time limits established by DSHS for submission of claims. The provider understands that payment and satisfaction of such claims will be from federal and/or state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and /or state laws. Fraud is a felony, which can result in fines and imprisonment.

18. 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 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 Provider's 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 or entity is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on the person. The contract must be signed and dated by the Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according to the CSHCN Services Program 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 CSHCN Services Program.

•Biller understands that they may be criminally convicted and subject to penalties or recoupment of overpayments 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 penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings directly or indirectly, to the Biller or to the CSHCN Services Program or its 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 CSHCN Services Program.

•Biller agrees to enroll and be approved by the CSHCN Services Program as a Third Party Billing Vendor prior to submitting claims to the CSHCN Services Program on behalf of the Provider.

•Biller and Provider agree to notify the CSHCN Services Program within 5 working days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

19. To be payable by CSHCN Services Program, services must be personally performed by a physician or by a qualified person working under the personal or direct supervision of the physician. Personal supervision means that the physician must be in the building of the office or facility when and where the service is provided. Direct supervision means the physician must be physically present in the room at the time the service is provided. In instances where one physician is taking calls for another physician, the performing physician must bill the services provided.

20. Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct, are received by DSHS or its designee within CSHCN Services Program deadlines, and to implement an effective method to track submitted claims against payments made by DSHS or its designee.

21. Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund to CSHCN Services Program any overpayments, duplicate payments, and or erroneous payments to which entitlement is not authorized under CSHCN Services Program rules and regulations that are paid to Provider by CSHCN Services Program or its designee as soon as the payment error is discovered.

22. To comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), Sections 504 of the Rehabilitation Act of 1973 (Public Law 93-112), The Americans with Disabilities Act of 1990 (Public Law 101-336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the provider agrees to comply with Title 40, Chapter 73, of the TAC. These provide, in part, that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination. To comply with Texas Health and Safety Code, Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).

23. Provider agrees to not discriminate against the individual on the basis the person is a CSHCN Services Program recipient by means of pricing differentials or other means of discriminatory treatment. Provider must not exclude or deny aid, care, service, or other benefits available under CSHCN Services Program 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 CSHCN Services Program 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 CSHCN Services Program 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 CSHCN Services Program for CSHCN Services Program recipients and discounted services to the general public must not be billed to CSHCN Services Program for a CSHCN Services Program recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

24. To provide language assistance that may be required for effective communication with CSHCN Services Program recipients who demonstrate limited English proficiency to insure they have equal access to services.

25. To accept responsibility for informing and ensuring that those acting as my agents understand and follow CSHCN Services Program rules and regulations.

26. To comply with all requirements of CSHCN Services Program regulations, rules, standards, and guidelines published by CSHCN Services Program or its designee.

27. To maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

28. To promptly report change of address and/or change in status, including but not limited to change in name, loss of license, change in certification status, or change in Medicaid provider status.

29. To maintain provider enrollment and participation in the Texas Medicaid Program as a condition to participate in CSHCN Services Program. Should Texas Medicaid status be terminated, participation in CSHCN Services Program may be terminated effective the date of Medicaid termination.

30. That this agreement may be terminated by either party upon thirty (30) days notice to the other party, except that termination may be earlier for submitting false or fraudulent claims, failing to provide and maintain quality services or medically acceptable standards, failure to comply with the provider agreement signed at the time of application or renewal for CSHCN Services Program participation, disenrollment as a Medicaid provider or violation of the standards of CSHCN Services Program rules and regulations or parts thereof. Provider specifically agrees that Paragraphs 2, 3, and 27 of this Agreement concerning client record retention, access by DSHS to records pertaining to CSHCN Services Program services, and confidentiality of client records and information shall remain in effect and binding upon provider if the remainder of this Agreement is terminated for any reason.

31. DSHS and the CSHCN Services Program expect providers to comply with the provisions of State law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform DSHS 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.

The applicant must sign the agreement if enrolling as an individual.

I agree to the terms and conditions above: ☐

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Final Acknowledgement

Application Summary

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.

The PDF may take several minutes to load. Please wait until the PDF displays before moving forward.

I acknowledge that the application is complete and correct.

Agreement

By submitting this application for provider enrollment or credentialing, as well as the information provided in connection with this application, I acknowledge that I intend to become enrolled or credentialed as a provider in the Texas State Programs. I also agree to adhere to all applicable laws, administrative rules, policies, and guidelines, and I understand that under these authorities I must adhere to standards of behavior that, if not met, can result in administrative, civil and/or criminal sanctions.

I Decline | I Accept

Once the application is accepted and submitted, you will not be able to make modifications during TMHP processing.

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Enrollment Print

Application Status	PEP Ticket Number
Submitted	**11353372**

Thank you for submitting your application to the Texas Medicaid & Healthcare Partnership (TMHP). You can check the status of your application anytime by visiting www.tmhp.com, selecting Access Provider Enrollment, and clicking View Existing Transactions.

If you have chosen to apply with Medicaid and the CSHCN Services Program at the same time, applications for both programs will be processed concurrently. You may also apply for the CSHCN Services Program once your application to Medicaid has been approved and you have received a Medicaid Texas Provider Identifier (TPI).

Print Options

You can obtain an electronic copy of your online application in 24 hours.

To print for your personal records, log onto www.tmhp.com to View Existing Transactions. Navigate to the Messages screen to locate the Portal Ticket number of the submitted application.

Adobe Acrobat 7.0 or greater is required to view and print from Provider Enrollment on the Portal. You must print the required documentation in order to complete the application process. All forms with a signature line require an original signature from the provider or an authorized representative of the provider. Computerized or stamped signatures are not permitted. Forms that are submitted without a hand-written signature will be rejected.

- Print Required Documentation

Please print the cover letter and submit with the required supporting documentation to expedite processing.

- Print Cover Letter

Print the final checklist for your records to confirm that all applicable documentation is included for TMHP to complete processing of your application.

Final Checklist

Online Survey on the usability of Provider Enrollment on the Portal

Online Survey

Quick Links: Provider Demographics | Provider Information Form | Provider Acknowledgement

Final Checklist

1. Complete the Following Required Forms

All items marked with a red dot are required.

- ☐ **HHSC Medicaid Provider Agreement** (One for each group, performing provider within the group, individual, and facility included in this enrollment package)
- ☐ **IRS W-9 Form** (Excluding Performing Providers)
- ☐ Corporate Board of Directors Resolution Form (Corporations Only) — **Must Be NOTARIZED**
- ☐ Medicaid Audit Form (Facilities Only)

2. If Applicable, Complete the Following Optional Forms

- ☐ Electronic Funds Transfer (EFT) Authorization Agreement
- ☐ Send a Copy of Voided Check
- ☐ CSHCN Services Program - Required Information for Stem Cell Transplant Facility Providers Form
- ☐ CSHCN Services Program - Required Information for Dental/Orthodontia Providers Form
- ☐ CSHCN Services Program - Required Information for Customized Durable Medical Equipment (DME) Providers Form
- ☐ CSHCN Services Program - Required Information for Physician and Dentist Providers of Cleft/Craniofacial Surgical Services Form
- ☐ CSHCN Services Program - Providers Affiliated with a Comprehensive C/C Team Form
- ☐ Medicaid Women's Health Program Certification form

3. Obtain Signatures

These must be original signatures. Sworn Statements must be properly notarized by a Notary Public. *All items marked with a red dot require signatures.*

- ☐ **HHSC Medicaid Provider Agreement**
- ☐ **IRS W-9 Form** (Excluding Performing Providers)
- ☐ Corporate Board of Directors Resolution Form (Corporations Only) — **Must Be NOTARIZED**
- ☐ Electronic Funds Transfer (EFT) Authorization Agreement
- ☐ If applying for THSteps Dental, Dental Provider Agreement
- ☐ If applying for CSHCN Services Program, DSHS-CSHCN Services Program Agreement

4. Send all Required Documents

- ☐ **Ambulance Services Providers** — Send a copy of your permit/license
- ☐ **Birthing Center Providers** — Send a copy of your certification permit
- ☐ **Certified Registered Nurse Anesthetist Providers** — Send a copy of your CRNA certification or re-certification card
- ☐ **Chemical Dependency Treatment Facility Providers** — Send a copy of your license
- ☐ **CLIA Providers** — Send a copy of your CLIA license with approved specialty services as appropriate
- ☐ **ECI Providers** — Send a copy of your approval letter from the Interagency Council on Early Childhood Intervention
- ☐ **FQHC Providers** — Send a copy of your contracted providers, names and addresses of your satellite centers that have been approved by the Public Health Service, and a copy of your grant award
- ☐ **Mammography Services Providers** - Send a copy of certification of your mammography systems from the Bureau of Radiation Control (BRC).
- ☐ **MH/MR Providers** — Send a copy of your approval letter from the State of Texas
- ☐ **Case Management for Children and Pregnant Women Providers** — Send a copy of your approval letter from the State of Texas
- ☐ **Country of Citizenship** - Send a copy of your Green Card, Visa or other documentation demonstrating your rights to reside and work in the United States.
- ☐ **Freestanding RHC Providers** — Send a copy of your encounter rate letter from Medicaid
- ☐ CLIA Certificate
- ☐ Out of State Providers - Send proof of meeting one of the following criteria:
  - 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.

☐ Existing Medicaid Texas Provider Identifiers (TPIs): (Please list all other assigned Texas Medicaid TPIs)

5. If incorporated, the additional information below must accompany your application

☐ Certificate of Formation and Certificate of Filing or Certificate of Authority

☐ IRS 501(c)(3) Exemption Letter

☐ Letter of Good Standing

6. Make a Copy for Your Records and Mail Documentation

Please make a copy of all documents for your own records.

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested. Submit a cover letter listing the contact address and phone number to have deficiency letters mailed elsewhere.

Mail your documents to the following address:

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