DCN: 200925839002432

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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

SOREN VINDEKILDE
7037 CAPITOL
HOUSTON TX 77011

Kintana # 3744820

Intitals: JV Date: September 15, 2009

Dear Soren Vindekilde,

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

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

The provider enrollment application process cannot be completed if the requested information is not received within 30 days of the date of this letter. If you have any questions, please call the TMHP Contact Center at 1-800-925-9126, and select Option 2.

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

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

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Texas Medicaid Identification Form

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

Section A Provider of Service Information

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

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

☐ Please provide the primary taxonomy code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section D Required Information for Specific Provider Types

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

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

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

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

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

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

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

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

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

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

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

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Provider Information Form

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

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

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

Principal Information Form (PIF-2)

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

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

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

Disclosure of Ownership and Control Interest Statement

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

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

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

☐ An original signature is required.

IRS W-9 Form

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

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

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

☐ The address is required.

Corporate Board of Directors Resolution

☐ The entire form must be completed.

☐ The form must be notarized.

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

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

Director's Resolution.

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

Electronic Funds Transfer Authorization Agreement

☐ Please provide the provider name and accounting address.

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

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

☐ Please provide the account number.

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

☐ Please provide the signature and date.

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

Additional Forms

☐ Please provide the Medicaid audit information.

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

☐ Please provide the Dental Specialty Form.

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

☐ Please provide a Certificate of Good Standing.

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

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

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

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

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

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Comments:

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Page 7.1
Accepting New Clients must be answered yes or no
Counties Served must be answered
Client Age Restrictions- must be answered- can be "none"
Gender Limitations- must be answered- can be "none"

Page 7.3 Section B must be completed with owners information

Page 9.2
License issue date in MM/DD/YY format

Page 9.3 all yes or no questions must be answered- 2nd from top is blank

Need PIF 2 Pages 9.4-9.6 for owners

Need Disclosure of Ownership pages 10.1-10.2 completed

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

Enclosures

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