Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Contractor (Capitation)
Enrollment/Revalidation Application

Instructions:

1. **Action Requested:**

   Check the applicable box – "Enrollment" or "Revalidation"

   If "Enrollment" is checked - enter the effective date of Enrollment
   Or
   If "Revalidation" is checked - enter your 13 digit PROMISe™ ID number and effective date of enrollment

   Please complete the entire application.

2. **Enrollee's Name:**

   List the applicant's name. If operating under a fictitious business/doing-business-as (dba) name, attach copy of recorded/stamped fictitious business name statement/permit.

3. **Tax Identification Information (TIN):**

   List the enrollee's Federal Employer Identification Number (FEIN). Enclose verification of the TIN with your application (e.g., a copy of an IRS-generated document containing the IRS number and name). **Note: A W-9 is not acceptable proof of tax ID.)**

   Enter the legal name as shown on the tax ID, and the corresponding current address, telephone and fax numbers and contact information.

4. **Business Type:**

   Check the appropriate box for your business type (check one box only). Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable. For government owned entities, page 10 of the Ownership or Control Interest Form is required.

5. **Provider Type Number and Description:**

   This block is already completed.

6. **Provider Specialty Number and Description:**

   This block is already completed

7. **Program Eligibility Maintenance:**

   This block is already completed.

8. **Confidential Information:**

   The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions. If "Yes" is answered to any of the questions, provide a detailed explanation and include it with your completed enrollment application.

9. Physical Service Location:

List the physical address where services will be provided. A Post Office Box is not a valid service location. Complete a separate Page 4 of the application for each intended physical service location.

10. Mail To Information:

Indicate the address where you want correspondence to be mailed. (e.g. notification of enrollment)

11. Pay To Information:

Indicate address where payments will be sent in the event the ACH payment is declined.

12. Home Office Information:

Indicate the entity's headquarters address.

13. Sign and date the application, print your name and list your telephone number. The signature should be that of the individual applying for enrollment, or someone able to represent the facility applying for enrollment.

Additional Required Forms:

Also include as applicable:

- One DHS Outpatient Provider Agreement with original signature.
- Completed Ownership or Control Interest Forms
- Verification of Tax ID name and number.

Forward the completed application to:

DPW/OMHSAS
Business Partner Support Unit
Enrollment
Commonwealth Tower 12th Floor
303 Walnut Street
Harrisburg, Pennsylvania 17101

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health Contractor (Capitation)
Enrollment/Revalidation Application

1. Action Requested:

☐ Revalidation ☐ Enrollment

PROMISe™ ID ___ ___ ___ ___ ___ ___ ___ ___ ___/ ___ ___ ___ ___

Effective date of enrollment: _____

2. Enter Name of Enrollee:

_____

3. Tax Identification Information

Federal Tax ID Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

*A copy of the document generated by the Federal IRS with the name and IRS number must accompany this application.

Legal Name (must be same as denoted on tax ID): _____

Address: _____

City: _____ County: _____ State: _____ Zip Code (9 digit) _____

Telephone: (__ __ __) __ __ __-__ __ __ __ Fax: (__ __ __) __ __ __-__ __ __ __

Contact Name/Title: _____ Contact e-mail: _____

4. Business Type:

☐ Corporation ☐ Not-for-Profit ☐ Sole Proprietorship ☐ Partnership

☐ Estate/Trust ☐ Government Owned

5. Provider Type Number and Description: 07 / Capitation

6. Provider Specialty Number and Description: 072 / MCO - BH

7. Program Eligibility Maintenance: Behavioral Health MC

8. CONFIDENTIAL INFORMATION

Have you, any agent, or managing employee ever:

Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

☐ Yes ☐ No

Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

☐ Yes ☐ No

Had a controlled drug license withdrawn?

☐ Yes ☐ No

Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

☐ Yes ☐ No

In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☐ No

If you answered "Yes" to any of the questions above, you **must** provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated, and attach it to your application. Include the following information as applicable to the situation:

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g., felony, misdemeanor)

This section requires the original signature of the individual applying for enrollment.

Title	Printed Name
Original Signature	Date

9. Physical Service Location:

_____
Street (Note: List physical street address. A PO Box is not acceptable.)

_____ _____ _____
City State Zip (9 digit) County

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

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10. Mail To Information:

_____
Street

_____ _____ _____
City State Zip (9 digit) County

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

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11. Pay To Information:

_____
Street

_____ _____ _____
City State Zip (9 digit) County

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

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12. Home Office Information:

_____
Street

_____ _____ _____
City State Zip (9 digit) County

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

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13. I certify that the information provided in this enrollment package is true to the best of my knowledge.

_____ _____ _(____)_____ _____
Provider's Signature Printed Name Telephone Date

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
Behavioral Health HealthChoices

PROVIDER AGREEMENT

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

_____ (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

2. The provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients;

3. The provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information indicated above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program.

4. The provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.

5. The provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

   A. the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

   B. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

6. The provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.

7. The provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the provider, and will provide to the Department any information needed for the Department to conduct a background check of the provider and its owners.

8. The provider agrees that upon written request from the Department, it will disclose the identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

9. The provider agrees that if there is any change in the ownership or control of the provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the provider.

10. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

PROVIDER ELIGIBIITY AGREEMENT

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance Program that the information submitted in or with this application is true, accurate and complete.

I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. §4904, relating to any unsworn falsifications to authorities.

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance Program.

_____ _____

Provider, Owner, or Authorized Agent – Original Signature Date

_____

Name – Please Type or Print