Dear Applicant:

Thank you for choosing to become a Montana Medicaid Provider. For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. All sections of the provider enrollment form must be completed in order for us to process your application. **Incomplete applications will be returned.** This application has been designed to comply with federal program requirements. We cannot accept alterations to the provider agreement text on pages 4 and 5.

You will be notified in writing of the status of your enrollment request within fifteen (15) working days of receipt at our office. Please do not bill Montana Medicaid for any services until you have received, in writing, notice of your provider number and its effective date. Claims submitted prior to completion of provider enrollment will be denied.

If you have any questions regarding information required on the enrollment application, please contact ACS Provider Relations at 1-800-624-3958 (in-state only) or 406-442-1837 (out-of-state and Helena).

All Providers

___ 1. Complete and sign the enclosed application.

If the application is for an individual, the individual who will be providing the service must sign it.

If the application is for a facility, an individual authorized to enter the facility into a legal contract must sign it.

___ 2. Complete Question 21 unless you are a Public Health Clinic or a facility with a non-profit tax status (indicate non-profit for Question 7 and on your W-9). An incomplete response to Question 21 will result in the enrollment form being returned.

If the enrolling facility is a non-profit organization or if no individual in the facility has controlling interest of five percent (5%) or more, please enter the information of the person who is the managing officer of the facility as a contact person.

___ 3. Enclose a **photocopy of your current license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also enclose a photocopy of your license covering that date of service. You may also be required to enclose a photocopy of your Medicare Certification Notice. Retroactive enrollment is not guaranteed.

___ 4. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number.

___ 5. On page 2, No. 10, please indicate the date that you want your provider number to be effective.

____6. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Direct Deposit Sign-Up Form (Standard Form 1199A). Failure to return this form will result in the entire provider enrollment package being returned to the provider. **Providers enrolling for new provider numbers cannot choose options 3 or 4 on this form.**

____7. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Electronic Remittance Advice and Payment Cycle Enrollment Form. Failure to return this form will result in the entire provider enrollment package being returned to the provider.

Laboratory Services

___ If you bill laboratory services, you must enclose a copy of your CLIA certification.

Pharmacy

___ If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's NABP number, you must indicate an effective date after the termination date for the previous provider.

Montana Medicaid
Provider Enrollment Application

Please type or block print the requested information as completely as possible. If any field is not applicable, please enter N/A. If you need extra space to answer any question, please attach an additional page. An incomplete form may delay the approval of this application. Please direct questions to the ACS Provider Relations Unit at (800) 624-3958 (Montana) or (406) 442-1837 (Helena and out-of-state).

For Fiscal Agent Use Only	
ACS Assigned Provider Number	**Approval Date**
_____	_____

IMPORTANT: PLEASE READ INSTRUCTIONS ABOVE QUESTIONS COMPLETELY BEFORE PROCEEDING

1. Enter your **business or provider name** and address below. **(Physical address is required.)**

   _____
   Name

   _____
   Address

   _____
   City State Zip

2. Enter your **practice telephone** and fax number.

   (_____) _____ - _____

   (_____) _____ - _____ (Fax)

3. Enter your two-digit **County Location Code.** Refer to *Table 1a or 1b* included in this enrollment application.

   _____/_____

4. **Pay to:** If you wish to direct your Remittance Advice to an address other than your practice address, enter that information here.

   Pay to Address: _____

   _____

   _____

   Correspondence: If you wish to have all Medicaid related correspondence sent to an address other than your practice address, enter that information here. **Please note that ACS can only store two provider addresses. Example: If your correspondence address is different than your payment or practice address, we cannot cross-reference the third address.**

   Correspondence Address: _____

   _____

   _____

   For Hospitals Only: Before payment can be made to your hospital for services provided to Montana Medicaid recipients, the name and address of your Medicare intermediary **must** be provided.

   Medicare Intermediary Address: _____

   _____

   _____

5. Enter your most current **Professional License Number**, state where issued, effective date and expiration date in MMDDYY format. The provider type indicated in Question 4 will determine which certification/license requirements must accompany your enrollment. Please refer to *Table 4*. **(ATTACH A COPY OF YOUR LICENSE.)**

_____	_____	_____/_____/_____	_____/_____/_____
License Number	State	Effective Date	Expiration Date

6. Enter your two-digit **Provider Type Code**. Refer to *Table 2* included in this enrollment application. _____/_____

7. Enter the two-digit **specialty code, board certified information, certification date in MMDDYY format, and certification number.** Refer to *Table 3* included in this enrollment application.

   Specialty Code: _____ Board Certified (Yes/No): _____

   Certification Date: _____ Certification Number: _____

8. Enter your one-digit **Type of Ownership Code**. Refer to the following *table* for codes. _____

0 –Other	2 – Partnership	4 – Hospital Based	6 – Group
1 – Individual	3 – Corporation	5 – HMO	7 – Clinic

9. Enter the **Federal Identification Number of the business OR the Social Security Number** of the individual for which this application is being filed. Use the number you wish all income to be reported for Federal 1099 purposes and match the information indicated on your W-9.

   FEIN _____ or SSN _____

10. Enter your **Drug Enforcement Agency (DEA) number**. If you do not have a DEA number, enter N/A in this space. If you are a physician, you **must** enter this information. _____

11. Enter your **fiscal year end month:** _____

12. If you bill laboratory services, you must enter your ten-digit **Clinical Laboratory Improvement Amendments (CLIA) number,** CLIA type, and effective and termination dates in MMDDYY format. CLIA type values are listed below.

1 Registration	2 Regular Certificate	3 Accreditation
4 Wavier	5 Microscopy	6 Partial Accreditation

_____	_____	_____/_____/_____	_____/_____/_____
CLIA Number	CLIA Type	Effective Date	Termination Date

13. **For Pharmacies Only:** Enter your **National Association of Boards of Pharmacy (NABP) number.** _____
    If you are a pharmacy that has purchased another pharmacy, do you wish to keep the same dispensing fee? ☐ No ☐ Yes

14. **For oxygen and PASSPORT providers only:** Enter your **24-hour access telephone number:** (_____) _____ - _____

15. If you have previously billed Montana Medicaid, indicate the provider number you used: _____

16. Have you already provided services to a Montana Medicaid recipient? ☐ No ☐ Yes

    If yes, enter the earliest date of service. _____ **Attach a copy of your license to cover this time period.**

17. If you are enrolled in the Medicare program, enter the **Unique Physician Identification Number (UPIN)** assigned to you:

    _____

18. If you enrolled as a Medicare provider, enter your **Medicare number** if you wish to have your claims automatically transferred from Medicare to Medicaid: _____

19. If you have been assigned a **National Provider Identifier (NPI)** number, enter your NPI number: _____

20. **OWNERSHIP INFORMATION**

(Copy this page and complete for each person who has an ownership or control interest of 5% or more, OR is an agent or managing employee in this provider entity.)

A. Name (First, Middle, Last, Jr., Sr., MD, DO, etc.)	Date of Birth	
County/State/Country of Birth	Social Security Number	Montana Medicaid No.
Are you the spouse, parent, child, or sibling of other persons who have an ownership or control interest of 5% or more, OR an agent or managing employee in this provider entity? ☐ No ☐ Yes (If yes, give name of person and relationship.)		
Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any Federal agency or program: ☐ No ☐ Yes If yes, please explain:		
B. Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? ☐ No (Go to Section C.) ☐Yes (Fill in the following for each organization. Attach a copy of the organization's form IRS-P575 or, if not available, the W-9.)		
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
C. Parent/Joint Venture Information Is your organization a subsidiary company or joint venture? ☐ No ☐ Yes If yes, fill in the following information about your parent company/joint business.		
Legal Business Name:	Employer ID No:	Medicaid ID No:
Business Street Address Line 1		
Business Street Address Line 2		
City	County	State / Zip
Phone Number	Fax Number	

DEFINITIONS

Ownership interest means equity in the capital, the stock or the profits of the provider.

Person with an ownership or control interest means a person, partnership, corporation or other entity that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the provider or in an entity that has an indirect ownership interest in the provider.

21. **INDIVIDUAL ENROLLMENTS ONLY:** The U.S. Department of Health and Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.

Gender: ☐ Male ☐ Female

Race: ☐ Asian or Asian American or Pacific Islander ☐ Hispanic ☐ White (not Hispanic) ☐ Black (not Hispanic) or African-American ☐ North American Indian or Alaska Native

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Printed Name of Person Filling out Form: _____ Date: _____

Signature of Person Filling Out Form: _____ Telephone #: _____

Provider Agreement and Signature

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, including but not limited to policies contained in the Medicaid provider manuals, and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills Medicaid will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply, as of December 1, 1991 and throughout the remaining term of this enrollment, with the applicable advance directive requirements of Section 1902(w) of the Social Security Act.

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (4-88) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer of employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, martial status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or and any active connected with the provision of Medicaid services.

All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider further agrees to, in accordance with relevant laws, regulations and policies, including the 1996 Department Policy on Confidentiality of Client Information, protect the confidentiality of any material and information concerning an applicant for or recipient of Medicaid services.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively the Department for the rate period.

The Provider agrees to notify ACS at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought. I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Printed Name of Individual Practitioner:	
Signature of Individual Practitioner:	Date:

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative	Title/Position:
Address:	Telephone Number:
Signature of Authorized Representative:	Date:

Please mail this completed enrollment form to:

ACS
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
| | | – | | – | | | |

or

Employer identification number
| | – | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person ►** **Date ►**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see ***Exempt from backup withholding*** above.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

Table 1a
Montana County Codes

01	Beaverhead	16	Gallatin	31	Mineral	46	Sheridan
02	Big Horn	17	Garfield	32	Missoula	47	Silver Bow
03	Blaine	18	Glacier	33	Musselshell	48	Stillwater
04	Broadwater	19	Golden Valley	34	Park	49	Sweet Grass
05	Carbon	20	Granite	35	Petroleum	50	Teton
06	Carter	21	Hill	36	Phillips	51	Toole
07	Cascade	22	Jefferson	37	Pondera	52	Treasure
08	Choteau	23	Judith Basin	38	Powder River	53	Valley
09	Custer	24	Lake	39	Powell	54	Wheatland
10	Daniels	25	Lewis & Clark	40	Prairie	55	Wibaux
11	Dawson	26	Liberty	41	Ravalli	56	Yellowstone
12	Deer Lodge	27	Lincoln	42	Richland	70	Warm Springs
13	Fallon	28	Madison	43	Roosevelt	71	Galen
14	Fergus	29	McCone	44	Rosebud	72	Boulder
15	Flathead	30	Meagher	45	Sanders	74	Eastmont

Table 1b
Out-of-State County Codes

AL	Alabama	IL	Illinois	NE	Nebraska	RI	Rhode Island
AK	Alaska	IN	Indiana	NV	Nevada	SC	South Carolina
AZ	Arizona	IA	Iowa	NH	New Hampshire	SD	South Dakota
AR	Arkansas	KS	Kansas	NJ	New Jersey	TN	Tennessee
CA	California	KY	Kentucky	NM	New Mexico	TX	Texas
CO	Colorado	LA	Louisiana	NY	New York	UT	Utah
CT	Connecticut	ME	Maine	NC	North Carolina	VT	Vermont
DE	Delaware	MD	Maryland	ND	North Dakota	VA	Virginia
DC	District of Columbia	MA	Massachusetts	OH	Ohio	WA	Washington
FL	Florida	MI	Michigan	OK	Oklahoma	WV	West Virginia
GA	Georgia	MN	Minnesota	OR	Oregon	WI	Wisconsin
HI	Hawaii	MS	Mississippi	PA	Pennsylvania	WY	Wyoming
ID	Idaho	MO	Missouri				

TABLE 2
PROVIDER TYPES

01	Inpatient Hospital	17	Psychologist	35	Nutritionist	55	Rural Health Clinic
02	Outpatient Hospital	18	Dentist	38	Residential Treatment Center	56	FQHC
03	Swing Bed Hospital	19	Pharmacy	39	ICF – Mentally Retarded	58	Licensed Professional Counselor
04	EPSDT	20	Durable Medical Equipment	40	Lab and X-Ray	59	Mental Health Center
05	Podiatrist	21	Optometrist	42	Licensed Social Worker	60	Targeted Case Management (Mental Health Only)
06	Physical Therapist	22	Eyeglasses	43	Denturist	61	Therapeutic Group Home
07	Speech Therapist	23	Transportation – Common	44	Mid-level Practitioner	63	Public Health Clinic
08	Audiologist	24	Non-Emergency Transport	45	Schools	64	Therapeutic Foster Care
09	Hearing Aids	25	Ambulance	46	Home Infusion Therapy	65	Psychiatrist (MD or DO)
10	Occupational Therapist	26	Nursing Home	47	Eyeglasses Contractor	66	CHIP Dental
12	Personal Care	27	Physician	50	QMB Chiropractor	72	Independent Diagnostic Testing Facility
13	Home Dialysis	28	Home and Community Based	52	Freestanding Dialysis Clinic	99	EDI Billing Agent
14	Private Nursing	29	Targeted Case Management (Non-Mental Health)	53	Home Health	NP	Mail Only Provider
15	Ambulatory Surgical Center	32	Rehabilitation	54	Hospice		

TABLE 3
PROVIDER SPECIALTIES

01	General Practice	23	Peripheral Vascular Disease or Surgery	52	Rheumatology	74	Targeted Case Mgmt Pregnant Women
02	General Surgery	24	Plastic Surgery	53	General Dentist	75	Head Start
03	Allergy	25	Physical/Rehab Medicine	54	Neonatology	76	Community Mental Health
04	Otology/Laryngology	26	Psychiatry	55	Oncology	77	Nurse Midwife
05	Anesthesiology	27	Psychiatry Neurology	56	Respiratory Therapy	78	Home Infusion Therapy
06	Cardiovascular Disease	28	Proctology	57	School Based Services	79	Retail Pharmacy
07	Dermatology	29	Pulmonary Diseases	58	Other EPSDT	80	Orthotics/Prosthetics
08	Family Practice	30	Radiology	59	Chemical Dependency	81	Orthodontist
09	Gynecology	31	Roentgenology, Radiology	60	Therapeutic Group Care	82	Interpreter Services
10	Gastroenterology	32	Radiation Therapy	61	Therapeutic Foster Care	83	Managed Care Community
11	Internal Medicine	33	Thoracic Surgery	62	Other Rehab	84	Registered Nurse Anesthetists
12	Manipulative Therapy	34	Urology	63	Inpatient Psychiatric	85	Hospital Pharmacy
13	Neurology	35	Chiropractor	64	Residential Treatment	86	Nursing Facility Pharmacy
14	Neurological Surgery	36	Nuclear Medicine	65	Outpatient Hospital Lab	87	Pedodontist
15	Obstetrics	37	Pediatrics	66	Eyeglass Material Supplier	88	Endocrinology
16	OB-Gynecology	38	Geriatrics	67	Wheelchair Supplier	89	TCM Mental Health
17	Ophthalm-Ot-Laryng-Rhinology	39	Nephrology	68	HMO	90	TCM Developmental Disability
18	Ophthalmology	40	Hand Surgery	69	MHO	91	TCM Children at Risk
19	Oral Surgery	47	Psychology	70	Clinic/Other	92	Nurse Practitioner
20	Orthopedic Surgery	48	Podiatry	71	Ambulatory Surgery Center	99	Unknown
21	Pathologic Anatomy	50	Certified Nurse Specialist	72	Diagnostic Clinic		
22	Pathology	51	Physician Assistant	73	Public Health Clinic		

Table 4

Please find the provider type that you indicated in Question 5 to determine which certification/license requirements must accompany your enrollment.

Provider Type	Certification/License Required
01 – Inpatient/Outpatient Hospital	Worksheets A, A8, C, Part 1 and G2 most recent Medicare cost reports and license (if out-of-state hospital, cost report is not required)
02 – Outpatient Hospital Only	Worksheets A, A8, C, Part 1 and G2 most recent Medicare cost reports and license
03 – Swing Bed Hospital	License
04 – EPSDT Chiropractors	License
04 – EPSDT Respiratory Therapy	License
45 - Schools	Each school must complete an enrollment form. School psychologists must include copy of class 6 specialist license with school psych. endorsement CSCT services – copy of contract btwn MHC and school must be included
05 – Podiatrists	License
06 – Physical Therapist	License
07 – Speech Therapist	License
08 – Audiology	License
09 – Hearing Aid Dispensers	License
10 – Occupational Therapists	License
12 – Personal Assistance Providers	This does not include personal care facilities. Self-directed personal assistance indicate specialty 70 on page 1
17 – Psychologists	License
18 – Dentists	License
19 – Pharmacies	License
46 – Home Infusion Therapy	License. Please indicate provider specialty 78 on page 1
21 – Optometrists	License
23 – Transportation – Common Carriers	Class B Commercial License (Taxicabs) Air Carrier Certificate (Air Charter) Business License (Travel Agency) Or Federal Highway Administration
24 – Transportation – Specialized Non-Emergency	Class B Commercial License or letter from the PSC
25 – Ambulance (Air or Ground)	License
26 – Nursing Facility	License
27 – Physician	License
28 – Home and Community Based Services	Facilities – license for personal care facility or adult foster home
29 – Targeted Case Management	Must enter specialty on page 1
35 – Nutritionist	License
38 – Residential Treatment Centers	License
40 – Independent Laboratories	CLIA Certification
42 – Social Worker	License
43 – Denturists	License
44 – Mid-level Practitioners	License. Please indicate provider specialty on page 1
44 - Physician Assistants	License
50 – Chiropractor (QMB Only)	License
52 – Free Standing Dialysis	License, Medicare Certification and copy of composite rates
53 – Home Health	License, CMS Certification and Montana Medicaid surety bond
54 – Hospice	License and CMS Certification
55 – Rural Health Clinics	License and Medicare Certification
56 – Federally Qualified Health Centers	License and Medicare Certification
58 – Licensed Professional Counselors	License
59 – Community Mental Health Clinics	Certification
60 – Targeted Case Management Mental Health Only	Certification
61 – Therapeutic Group Home	License
62 – Ambulatory Surgical Centers	License and Medicare Certification
64 – Therapeutic Foster Care	License
65 – Psychiatrist	License
72 – Independent Diagnostic Treatment Facility	Medicare Certification

ATTENTION:

All portions of the Ownership Information section of this enrollment application must be completed or your application will be returned. Following are additional guidelines to assist you in answering these questions. Definitions are printed on the bottom of page 3.

21A - **For non-profit organizations (facilities, Indian Health Services, Public Health Services):** Complete with an agent's or managing employee's name as a contact.

Other Enrollees: Indicate anyone with an ownership relationship with the tax ID of the provider enrolling or anyone who has interest of 5 percent (5%) or more.

All Enrollees: Answer the question related to sanction.

21B - Answer the question. If you answer yes, complete the business information and send either the IRS-P575 or W-9.

21C - Answer the parent/joint venture question. If you answer yes, complete the business information.

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active _____
- ☐ Mil. Retire._____
- ☐ Mil. Survivor _____
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER

CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENRATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

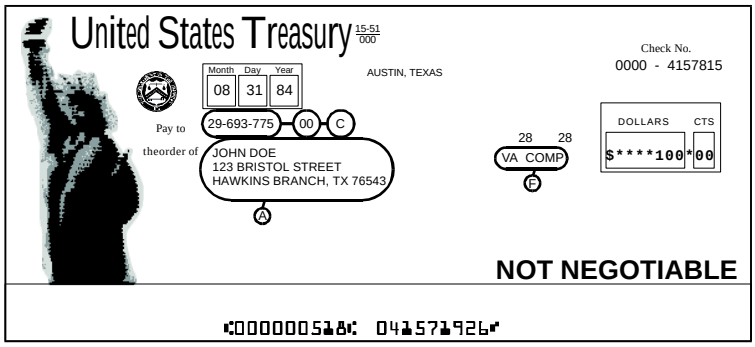
INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

Ⓐ Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓒ Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

DPHHS-MA-098A (Rev. 10/2003)

State of Montana
Department of Public Health & Human Services
Medicaid Services

ELECTRONIC BILLING AGREEMENT

_____ _____
(Provider Name) (Medicaid Provider Number)

_____ _____
(Provider Street Address) (City, State, Zip Code)

The undersigned provider hereby elects to submit claims by electronic means to the Montana Department of Health and Human Services medical assistance programs in accordance with the provisions stated herein.

The provider agrees that this election does not in any way modify the requirements of the policies and procedures for services, the Montana Medicaid Provider Enrollment Form or any other contract or agreement with the Department, except as to claim submission methods.

Amendments must be in writing and must be signed by the authorized representative of the contracting parties. This agreement shall not be verbally amended.

The provider and the department agree that each party to this agreement shall have the right to unilateral termination of their agreement upon delivery of written notice of termination of the other party.

The provider and/or his intermediary shall provide, upon the request of the state, supportive documentation to ensure that all technical requirements are being met. Examples of supportive documentation include, but are not limited to, program listing, tape dumps, flow charts, file descriptions, accounting procedures and the like.

The provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the provider, if he selects a data processing agent to submit medical assistance claims directly, authorizes the agent to act for the provider to submit claims on the provider's behalf. The provider acknowledges that their agent's submission of the provider's medical assistance claims to the department is on the provider's behalf, and the provider is responsible for the truth, accuracy, and completeness of the claims submitted.

The provider agrees to submit to the Montana Department of Public Health and Human Services or its authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.

The provider shall provide all documentation requested during the course of a federal or state audit or investigation, concerning the nature, scope or existence of the services pertaining to a medical assistance claim. Should the provider fail to provide such documentation, the provider shall remit to the department the amount previously paid pertaining to the claim for which documentation has been requested. Should such remittance to the department not he made within thirty (30) days after a written demand is made therefore, the department is hereby authorized by the provider to deduct that amount from any amounts which may otherwise be due or become due to the provider.

Requirements for retention of source documents are as follows:

If claim information is transmitted to the intermediary by paper, either the intermediary or the provider must maintain the documents transmitted in accordance with department rules for records retention. Microfilm or microfiche copies may be maintained in place of original documents provided they meet the requirements defined in the Montana Records Management Policies and Procedures.

If claim information is transmitted electronically to the intermediary, the intermediary must maintain the tape, microfilm or microfiche containing the claim information in accordance with department rules for record retention.

The provider acknowledges that the following provider's certification statement, under which he endorses warrants in payment of medical assistance applies to all services he provides regardless of the method of submission to the Department of Public Health and Human Services:

I understand "That Endorsement" hereon or deposit to the accounts of the within named payee is done with the understanding that payment will be from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be prosecuted under applicable federal and state law.

The provider certifies that the services billed for will have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap.

The provider agrees to furnish to the department's claim processing agent copies of the written agreements with any intermediary that has been authorized to submit medical assistance claims in the provider's behalf.

The provider agrees that billing services and compensation for such will be related to the cost of processing the billing and acknowledges that it may not be related on a percentage or other basis to the amount that is billed or collected and may not be dependent upon the collection of that payment required by federal regulation or this agreement.

The provider agrees that any intermediary that has been authorized to establish receivables and make collections in their behalf shall have an effective system for identifying duplicate payments from other sources (third party) so as to ensure the Montana Department of Public Health and Human Services medical assistance programs' standing as the payor of last resort.

The provider agrees to require any intermediary they contract with to process medical assistance claims to send to the provider, at least monthly, a complete listing of claims processed in their behalf by the intermediary that identifies, at a minimum, the following: 1) patient name, 2) patient medical assistance ID number, 3) date of service, 4) service/procedure, 5) charged amount, 6) all payments,* 7) payment sources.* [Required only when an intermediary is contracted to establish receivables and make collections.] The provider agrees to personally review these reports.

All specifications set forth in the departments, "Electronic Billing Specifications," as from time to time amended, shall be met for every entry submitted. A copy of such procedures may be requested at anytime from ACS Provider Relations. The department agrees to supply the provider with any amendments to these specifications within a reasonable time prior to the time such amendments or changes to the procedures shall go into effect.

It is expressly understood that the department may reject an entire submission at any time for failure to comply with the "Electronic Billings Specifications" as in effect pursuant to the above paragraph or for any other valid reason.

The provider agrees to the obligation of researching and correcting any and all claim discrepancies caused by the provider or their contracted intermediary.

The provider understands that participation in the Montana medical assistance program(s) is subject to compliance with this agreement and Federal and State laws and regulations. Non-compliance is cause for termination of this agreement.

Signed this _____ day of _____, 20__

_____
(Provider Signature)

Distribution: Original to ACS EDI Gateway, Inc., ATTN: EDI Enrollment Unit; 2324 Killearn Center Blvd.; Tallahassee, FL 32309. Fax: 850.385.1705
Copy retained by Provider

ELECTRONIC REMITTANCE ADVICE AND PAYMENT CYCLE ENROLLMENT FORM

Provider #: _____

Provider Name: _____

Address: _____

City: _____

Phone Number: _____

Contact Name: _____

E-mail Address: _____

***Providers enrolling as of 01/01/04 for new DPHHS provider numbers can only select EFT options. Choosing any other option will mean that your form will be returned.

	Payment Method	Remittance Advice	Payments Received
Option 1	EFT	Electronic	Weekly
Option 2	EFT	Paper	Bi-Weekly

Please refer to the table above and indicate the Option that you want: _____

Provider Agreement: I agree to participate in the Department of Public Health and Human Services' Electronic Remittance Advice project. I understand that participation will require some time and effort on the part of myself or my office staff. I accept responsibility for accessing the Montana Eligibility and Payment System website and downloading the Electronic Remittance or an X12N 835 Remittance Advice from ACS EDI Gateway. I understand that the only way to receive weekly payments is to receive both Electronic Remittance Advice and Electronic Funds Transfer. At any time I may inform DPHHS in writing that I wish to discontinue receiving my Remittance Advice electronically, but also understand that then I can no longer receive weekly payments.

_____ _____

Provider Signature Date

Please mail this completed form to:

ACS Provider Relations
P.O. Box 4936
Helena, MT 59604

Revised: 07/12/05

MENTAL HEALTH SERVICES PLAN
PROVIDER ENROLLMENT ADDENDUM

Montana Medicaid Provider Number: _____

The individual or entity identified below has applied for enrollment and is enrolled as a provider in the Montana Medicaid Program ("Medicaid"), and has also requested enrollment as a provider under the Mental Health Services Plan established in ARM Title 46, Chapter 20 (the "Plan").

In consideration of enrollment in the Plan and Plan payments made to the Provider for covered medically necessary services under the Plan, the Provider acknowledges and agrees to the following:

As a condition of participation in the Plan, the Provider must be and remain enrolled as a Medicaid Provider. Participation in the Plan shall be limited to the category or categories of services which is a covered service under the Plan and for which the Provider is enrolled in Medicaid.

The Provider agrees to comply with and be bound by all applicable laws, regulations, rules and written policies pertaining to the Plan, and those Medicaid laws, regulations, rules and written policies applicable under the Plan, including but not limited to the Montana Code Annotated, the Administrative Rules of Montana and written policies of the Department of Public Health and Human Services (DPHHS).

DPHHS is authorized to use the information contained in the Provider's Medicaid Provider Agreement for purposes of administering the Plan. Provider acknowledges and agrees that the provisions of the Medicaid Provider Agreement shall apply to the Plan as if the Plan services were Medicaid services, except that this Addendum shall not be construed to make applicable to the Plan any provisions of State or Federal laws, regulations, rules and policies not otherwise applicable to the Plan.

Enrollment in the Plan under this Addendum shall be effective according to the same provisions applicable to Medicaid enrollment under ARM 46.12.302. This addendum shall terminate, without affecting the Provider's Medicaid Provider Agreement, upon written notice by DPHHS to the Provider or upon the termination of the Plan.

This Addendum shall be a part of the Provider's Medicaid Provider Agreement for purposes of governing the Provider's participation in the Plan. However, this Addendum shall not in any way reduce or modify the Provider's obligations under the Provider's Medicaid Provider Agreement with respect to participation or provision of services under the Montana Medicaid Program.

Individual Practitioner Name Printed	
Individual Practitioner Signature	Date
or for facilities and non-practitioner organizations:	
Authorized Representative Name Printed	Title/Position
Address	Telephone Number
Authorized Representative Signature	Date

MONTANA
Department of Public Health & Human Services

Provider Requirements

Provider Enrollment

To be eligible for enrollment, a provider must:

- Provide proof of licensure, certification, accreditation or registration according to Montana state laws and regulations.
- Provide a W-9.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.

Medicaid payment is made only to enrolled providers.

Providers must complete a *Montana Medicaid Provider Enrollment Form*, which is a contract between the provider and the Department. Each provider is assigned a Montana Medicaid provider number, which should be used in all correspondence with Medicaid. Providers must apply for a Medicaid ID number for each type of service they provide. For example, a pharmacy that also sells durable medical equipment (DME) must apply for a Medicaid ID for the pharmacy and another ID for DME. To enroll as a Montana Medicaid provider, visit the Provider Information website or contact Provider Relations (see *Key Contacts*).

Enrollment materials

Each newly enrolled provider is sent an enrollment letter with the new Medicaid provider number and instructions for obtaining additional information from the Provider Information website.

Most Medicaid-related forms are available in the provider manuals and on the Provider Information website. To order additional forms, complete and mail or fax the order sheet located in *Appendix C: Forms*. We do not provide CMS-1500, UB-92, or dental claim forms.

Medicaid renewal

For continued Medicaid participation, providers must maintain a valid license or certificate. For Montana providers, licensure or certification is automatically verified and enrollment renewed each year. If licensure or certification cannot be confirmed, the provider will be contacted. Out-of-state providers will be notified when Medicaid enrollment is about to expire. To renew enrollment, mail or fax a copy of your license or certificate to the Provider Relations Unit (see *Key Contacts*).

Out-of-state providers can avoid denials and late payments by renewing Medicaid enrollment early.

To avoid payment delays, notify Provider Enrollment of an address change in advance.

Changes in enrollment

Any changes in address, phone number, name, ownership, legal status, tax identification number, or licensure must be submitted in writing to the Provider Relations Unit (see *Key Contacts*). Faxes are not accepted because the provider's original signature and provider number are required. For change of address, you can use the form in *Appendix C: Forms*, and you must include a W-9 form. The Postal Service cannot forward government-issued warrants (checks).

Change of ownership

When ownership changes, the new owner must apply for a new Montana Medicaid number. For income tax reporting purposes, it is necessary to notify Provider Relations at least 30 days in advance about any changes that cause a change in your tax identification number. Early notification helps avoid payment delays and claim denials.

Electronic claims submission

Providers who submit claims electronically experience fewer errors and quicker payment. Providers who are using any of the following electronic claims submission methods must enroll with the ACS EDI Gateway clearinghouse (see *Key Contacts*). All Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an X12N 837 transaction, but does not accept an X12N 835 transaction back from the Department.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12N 837 format using a dial-up connection. Electronic submitters are required to certify their X12N 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the X12N 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact ACS EDI Gateway or Provider Relations (see *Key Contacts*).

Terminating Medicaid enrollment

Medicaid enrollment may be terminated at any time by writing to the Provider Relations Unit. Include your provider number and the termination date in the letter. The Department may also terminate your enrollment under the following circumstances:

- Breaches of the provider agreement
- Demonstrated inability to perform under the terms of the provider agreement
- Failure to abide by applicable Montana and U.S. laws
- Failure to abide by the regulations and policies of the U.S. Department of Health and Human Services or the Montana Medicaid program

Authorized Signature (ARM 37.85.406)

All correspondence and claim forms submitted to Medicaid must have a Medicaid provider number and an authorized signature. The signature may belong to the provider, billing clerk, or office personnel, and may be typed, stamped, computer generated or signed. When a signature is from someone other than the provider, that person must have written authority to bind and represent the provider for this purpose. Changes in enrollment information require the provider's original signature.

Provider Rights

- Providers have the right to end participation in Medicaid at any time.
- Providers may bill Medicaid clients for cost sharing (ARM 37.85.406)
- Providers may bill Medicaid clients for services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services.
  - When the provider does not accept the client as a Medicaid client, it is sufficient for the provider to use a routine agreement to inform the client that he or she is not accepted as a Medicaid client, and that the client agrees to be financially responsible for the services received.
  - When the client has been accepted as a Medicaid client, but the services are not covered by Medicaid, the services can be billed to the client only after the provider has informed the client in writing (before providing the service) that those services are not covered by Medicaid, and the client has agreed to pay for the specific services on a private-pay basis. In this case, a routine agreement will not suffice. (ARM 37.85.406) For more information on billing Medicaid clients, see *Billing Procedures* in the specific provider manual.
- Providers have the right to choose Medicaid clients, subject to the conditions in *Accepting Medicaid clients* later in this chapter.

- Providers have the right to request administrative reviews and fair hearings for a Department action that adversely affects the provider's rights or the client's eligibility. (ARM 37.85.411)

Administrative Reviews and Fair Hearings (ARM 37.5.310)

If a provider believes the Department has made a decision that fails to comply with applicable laws, regulations, rules or policies, the provider may request an administrative review. To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department (see *Key Contacts* or the list of program policy contacts in the *Introduction* chapter of this manual). The Department must receive the request within 30 days from the date the Department's contested determination was mailed. Providers may request extensions in writing within this 30 days.

If the provider is not satisfied with the administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. This document must be signed and received by the Fair Hearings Office (see *Key Contacts*) within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered (or mailed) to the division that issued the determination within three working days of filing the request.

Provider Requirements

By signing the application to enroll in Montana Medicaid, providers agree to abide by the conditions of participation according to ARM 37.85.401. This section discusses some of those conditions; see the application for additional details and precise wording.

Accepting Medicaid clients (ARM 37.85.406)

Institutional providers, eyeglass providers, and non-emergency transportation providers may not limit the number of Medicaid clients they will serve. Institutional providers include nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, hospitals, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities.

Other providers may limit the number of Medicaid clients. They may also stop serving private-pay clients who become eligible for Medicaid. Any such decisions must follow these principles:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- Clients enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- When a provider arranges ancillary services for their Medicaid client through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly. See ARM 37.85.406 (d) for details.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective (see *Client Eligibility and Responsibilities*, *Retroactive Eligibility* for details).
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.
- Once a client has been accepted as a Medicaid client, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

Non-discrimination (ARM 37.85.402)

Providers may not discriminate in the provision of service to Medicaid clients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age, or disability. Providers shall comply with the Department of Health and Human Services regulations under Title VI and Title IX of the Civil Rights Act, Public Law 92-112 (Section 504 and 505) and the Montana Human Rights Act, Title 49, Chapter 2, MCA, and Americans with Disabilities Act as amended and all requirements imposed by or pursuant to the regulations.

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Client must be enrolled in Medicaid and non-restricted (see *Client Eligibility and Responsibilities* for restrictions). (ARM 37.85.415 and 37.85.205)
- Service must be medically necessary. (ARM 37.85.410) The Department may review medical necessity at any time before or after payment.

- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.82.102, 37.85.207, and 37.86.104)
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the *Billing Procedures* chapter of each manual, the most current provider notices and manual replacement pages, and according to ARM 37.85.406 (Billing, reimbursement, claims processing and payment) and ARM 37.85.407 (Third Party Liability).
- Charges must be usual and customary. (ARM 37.85.212 and 37.85.406)
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties ($75.00) is greater than the Medicaid fee ($70.00), Medicaid will pay at $0. (ARM 37.85.406)
- Claims must meet timely filing requirements (see *Billing Procedures* in the specific provider manual for timely filing requirements). (ARM 37.85.406)
- Prior authorization requirements must be met. (ARM 37.85.406)
- PASSPORT approval requirements must be met. (ARM 37.86.5101 - 37.86.5112)

Medicaid payment is payment in full (ARM 37.85.406)

Providers must accept Medicaid payment as payment in full for any covered service, except applicable cost sharing that should be charged to the client.

Payment return (ARM 37.85.406)

If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

Disclosure

- Providers are required to fully disclose ownership and control information when requested by the Department. (ARM 37.85.402)
- Providers are required to make all medical records available to the Department. (ARM 37.85.410 and 37.85.414)

Client services

- All services must be made a part of the medical record. (ARM 37.85.414)
- Providers must treat Medicaid clients and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by regulations). (ARM 37.85.402)

- Providers may not deny services to a client because the client is unable to pay cost sharing fees. (ARM 37.85.402)

Confidentiality (ARM 37.85.414)

All Medicaid client and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of health care information subject to applicable laws.

Record keeping (ARM 37.85.414)

Providers must maintain all Medicaid-related medical and financial records for six years and three months following the date of service. The provider must furnish these records to the Department or its designee upon request. The Department or its designees may audit any Medicaid related records and services at any time. Such records may include (but are not limited to) the following:

- Original prescriptions
- Certification of medical necessity
- Treatment plans
- Medical records and service reports including (but not limited to):
- Patient's name and date of birth
- Date and time of service
- Name and title of person performing the service, if other than the billing practitioner
- Chief complaint or reason for each visit
- Pertinent medical history
- Pertinent findings on examination
- Medication, equipment, and/or supplies prescribed or provided
- Description and length of treatment
- Recommendations for additional treatments, procedures, or consultations
- X-rays, tests, and results
- Dental photographs/teeth models
- Plan of treatment and/or care, and outcome
- Specific claims and payments received for services
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid clients

Providers are responsible for keeping informed about applicable laws, regulations, and policies.

- Records and original invoices for items that are prescribed, ordered, or furnished
- Any other related medical or financial data

Compliance with applicable laws, regulations, and policies

All providers must follow all applicable rules of the Department and all applicable state and federal laws, regulations, and policies. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails.

The following are references for some of the rules that apply to Montana Medicaid. The provider manual for each individual program contains rule references specific to that program.

- Title XIX Social Security Act 1901 et seq.
  - 42 U.S.C. 1396 et seq.
- Code of Federal Regulations (CFR)
  - CFR Title 42 - Public Health
- Montana Codes Annotated (MCA)
  - MCA Title 53 - Social Services and Institutions
- Administrative Rules of Montana (ARM)
  - ARM Title 37 - Public Health and Human Services

Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*).

Provider Sanctions (ARM 37.85.501 - 507 and 513)

The Department may withhold a provider's payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies.

Other Programs

This is how the provider requirements apply in Department of Public Health and Human Services (DPHHS or the Department) programs other than Medicaid.

Mental Health Services Plan (MHSP)

To be paid by MHSP, the provider must be enrolled as a Medicaid provider and, in addition, must sign an addendum to the provider enrollment agreement that is specific to MHSP. If a signed addendum is not on file when a claim is submitted to MHSP, payment will be denied until the addendum is received.

Adults enrolled in MHSP can only receive MHSP services from a contracted Mental Health Center. Children may obtain MHSP services from other enrolled licensed practitioners.
All other policies and procedures in this chapter apply to MHSP providers in the same way they apply to Medicaid providers.

Mental health services **for Medicaid clients** are included within the scope of the Medicaid provider agreement and the separate addendum need not be signed.

Children's Health Insurance Plan (CHIP)

For CHIP, the policies and procedures in this chapter apply only to providers of dental services and eyeglasses. Provider Relations for providers of CHIP dental services and eyeglasses is handled by the same DPHHS contractor as for Medicaid. Providers of these services will receive CHIP provider numbers that differ from Medicaid provider numbers they may already have.

For all other services, CHIP provider relations is administered by BlueCross BlueShield of Montana; call (406) 447-8647 in Helena or (800) 447-7828 x8647 statewide.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program

Providers of chemical dependency services must have a state-approved program, and the provider must sign a contract with the Department's Addictive and Mental Disorders Division for delivery of the covered services.