COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

www.virginiamedicaid.dmas.virginia.gov

Adult Care Residence

ASSESSMENT AND CASE MANAGEMENT SERVICES

ENROLLMENT PACKAGE

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Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
804-270-7027 or 888-335-8476 (Fax)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 10 business days. Virginia Medicaid Provider Enrollment Services is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance Programs including the enrollment of additional locations. Each practice location must be enrolled separately. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, Disclosure of Ownership & Control Interest Statement, and any required licensure documents. If the requested date of enrollment is more than one year in the past, supporting documentation and a claim for services rendered must be submitted with the completed Enrollment Application.

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) require covered health care providers to obtain and use a new 10 digit National Provider Identifier (NPI) in lieu of any other provider identification number(s) for all standard transactions. DMAS is expanding this requirement to its entire provider network, including providers not considered health care providers as defined by the NPI Final Rule. DMAS is requiring this change for Atypical providers in order to maintain the consistency and integrity of its Medical Management Information System.

Your provider category has been identified as an Atypical provider category. As such you will be assigned a 10-digit Atypical Provider Identifier (API) for you to use when your application is approved. Your new 10-digit API number is to be used on all Medicaid business transactions. (Claims, ARS, PA), including paper claims. Please note, the '1D' ID Qualifier must be used in fields 24I, 32b and 33b when submitting the new CMS-1500 version 08/05 because Atypical Providers are not required to submit an NPI.

Some Atypical Providers may have successfully obtained an NPI because they provide other services that qualify them as a healthcare provider according to the HIPAA rules. If this is the case and you have obtained an NPI, your NPI will supercede the DMAS assigned API. Please download the Atypical Provider NPI Attestation Form from the DMAS Website at http://www.dmas.virginia.gov/downloads/pdfs/hpa-npi_Atypical_Enum_Letter.pdf and follow the instructions in order to notify DMAS of your NPI.

Out-of-State Enrollment in Virginia Medical Assistance Programs

A provider must be located within 50 miles of Virginia's border to be enrolled as an in-state provider. When a provider not within the 50-mile radius renders services to recipients, the provider can request enrollment for the date(s) of service only. To be reactivated in any of the Virginia Medical Assistance Programs, out-of-state providers must submit claims for services rendered and a letter requesting reinstatement to the Provider Enrollment Unit.

Affiliated Computer Services, Inc. (ACS), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. ACS' Provider Enrollment Services is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Specialist by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at www.virginiamedicaid.dmas.virginia.gov. **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to ACS' Provider Enrollment Services at the following address or fax number:

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
804-270-7027 or 888-335-8476 (Fax)

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. National Provider Identifier (NPI)

Enter your 10-digit NPI as assigned by the National Plan and Provider Enumeration System (NPPES). If you are a business, enter your organization (Type 2) NPI. If you are an individual, enter your individual (Type 1) NPI. If you are an Atypical provider, leave this section blank.

2. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. If you have entered an organization (Type 2) NPI in field #1, you must enter a business name. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). If you have entered a Type 1 NPI in field #1, you must enter an individual name. This name is used to generate claim payments and report 1099 information.

3. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g (a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a) (1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

4. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g (a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group NPI, or you are individually incorporated.

5. IRS Name

Enter your IRS Name as it is registered with the IRS.

6. Fiscal Year End

The month in which fiscal year ends for your provider and the effective dates of the fiscal year. If there is not an end date, leave this section blank.

7. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment.

8. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

9. License/Certification Number

Enter the license/certification number indicated on licensing entity certification.

10. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

11. FDA Mammography Certification

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

12. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Number of Beds

If you are an institution, enter the number of beds for each type.

17. Administrator's Name

Enter the name of the administrator of the practice or facility.

Disclosure of Ownership & Control Interest Statement

This form must be completed and signed by an authorized representative.

Remarks

Enter any additional information or comments in the Remarks section of pages 1, 2 or both

ALL FORMS MUST BE SIGNED AND DATED

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Medical Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.virginiamediciad.dmas.virginia.gov.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. Enter your Primary Servicing Address in the Primary Servicing Address block on the Address Form

Note: For providers who are members of a Group Practice, enter the servicing address at which you practice and the Group NPI of the billing group that bills for your services rendered at that address.

2. Correspondence Address (Mandatory)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the ***Primary*** Servicing Address.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Correspondence Address. If there is no entry in the Correspondence Address section, the Remittance Advice will be sent to the ***Primary*** Servicing Address.

For ACS Use Only

Tracking Number_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

1. NATIONAL PROVIDER IDENTIFIER _____

2. LEGAL BUSINESS NAME: _____
(If applicable, as registered with the Internal Revenue Service)

OR

INDIVIDUAL NAME: _____ SUFFIX _____ TITLE _____
(Name of the provider who performs the service)

3. SOCIAL SECURITY NUMBER _____ EFFECTIVE DATE _____ END DATE _____

4. EMPLOYER TAX ID NUMBER _____ EFFECTIVE DATE _____ END DATE _____

5. IRS NAME _____

6. FISCAL YEAR END

Month _____ Begin Date _____ End Date _____

7. PROVIDER PROGRAM: ___ Medicaid ___ Medallion

___ Client Medical Management (CMM)

___ Temporary Detention Order (TDO)

___ Family Access to Medical Insurance Security Plan (FAMIS)

8. REQUESTED EFFECTIVE DATE OF ENROLLMENT _____

REMARKS:
_____

_____

_____

_____

9. LICENSE/CERTIFICATION NUMBER _____ LICENSING BOARD _____

ISSUING STATE AND ENTITY _____

10. PRIMARY SPECIALTY _____ LICENSING BOARD _____

SECONDARY SPECIALTY _____ LICENSING BOARD _____

11. FDA MAMMOGRAPHY CERTIFICATION NUMBER _____

12. CLIA NUMBER _____

13. TYPE OF APPLICANT (Please check one)

___ Individual ___ Corporation ___ Hospital Based Physician ___ Sole Proprietorship

___ Group Practice ___ Partnership ___ Health Maintenance Organization (HMO)

___ Limited Liability Partner

14. FACILITY RATING (Please check one)

___ Profit ___ Non-Profit ___ Not Applicable

15. FACILITY CONTROL (Please check one)

___ State ___ Private ___ Public

___ City ___ Charity ___ Not Applicable

16. NUMBER OF BEDS

___ NF ___ SNF-NF ___ SNF

___ Non-Cert ___ ICF-MR ___ Specialized Care

17. ADMINISTRATOR'S NAME _____

REMARKS:

_____

_____

_____

_____

SIGNATURE _____ DATE _____

Disclosure of Ownership & Control Interest Statement

This form must be completed by an Authorized Representative, who is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity. The signature on this form must be the written signature of the authorized representative and not a signature stamp.

Section I. Ownership and Control Information for Disclosing Entity. 42 C.F.R. 455.104

(a) List the name, title, address, and SSN for each **individual** who has any ownership or controlling interest in this provider entity or in any subcontractor. The individual's ownership or controlling interest is an ownership interest of 5% or more of this provider entity. List the name, Tax ID (TIN), and address of any **organization, corporation, or entity** having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities.

Name	Title	Address	SSN/TIN	Percentage

(b) List those persons named in Item II (a) that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

Name	Relationship	SSN	Percentage

(c) List the name, title, address, and social security number of each person with an ownership or control interest in any subcontractor that this disclosing entity has direct or indirect ownership of 5% or more. 42 C.F.R. §455.104

Name	Title	Address	SSN/TIN	Percentage

(d) List the name, address, and TIN of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more. 42 C.F.R. §455.104

Name	Title	Address	SSN/TIN	Percentage

Section II. Criminal Offenses 42 C.F.R. §455.100; 42 C.F.R. §455.106

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency?

   ___ NO ____ YES (If yes, attach a copy of any relevant final dispositions)

2. Has any individual or organization who has ownership or controlling interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

   ____ NO ____ YES (If yes, please provide the following information for the individual(s) or Organization(s) below. Attach additional copies of this form if necessary)

   Name Address SSN/TIN % of Ownership

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

3. Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

   ___ NO ___ YES (if yes, please provide the following information for the individual(s) or contractors(s) below. Attach additional copies of this form if necessary)

   Name Address SSN (or TIN if an organization)

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Signature of Authorized Representative _____ Date _____

ADDRESS FORM

PROVIDER NAME _____ **NPI** _____

PRIMARY SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

PAY TO ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

SIGNATURE _____ **DATE** _____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Adult Care Residence Assessment and Case Management Services Participation Agreement

This is to certify:

Provider Name _____ API _____
(Leave blank if unknown))

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider agrees to provide the assessments and/or case management services *(checked below)* for persons residing in or seeking admission to an adult care residence in accordance with all regulations, policies and procedures of VMAP which govern the provision of services in an adult care residence.

   _____Assessments for Authorization of Assisted Living Services
   _____Reassessments only
   _____Case Management of Assisted Living Residents
   _____Ongoing Case Management

2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U. S. C. §794), no handicapped individual shall, solely by reason of his physical or mental handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in provision of services.
3. Payment is to be made to those providers who actually render the services. Upon accepting a Medicaid recipient as a patient, the provider agrees to supply all items and services for the recipient in the same quality and mode of delivery which the provider supplies to the general public.
4. The Provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
5. The Provider agrees to conduct assessments and/or provide case management services for Medicaid recipients at the current rate established by VMAP as of the date of service.
6. Payment by VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any' service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
7. The Provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
8. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.
9. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated immediately by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
10. Except as otherwise provided by applicable state of federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
11. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
12. The Provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.
    This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.
13. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers; Information related to business transactions within 35 days of request.

For ACS's use *only*
Director, Division of Program Operations Date

Original Signature of Provider **Date**

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- ❑ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- ❑ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- ❑ **PHARMACY POINT-OF-SALE AUTHORIZATION:**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

NPI/API:: _____

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
804-270-7027 or 888-335-8476 (Fax)

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to Virginia Medicaid Provider Enrollment Services at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and ACS tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The Virginia Medicaid Provider Enrollment Services will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each NPI or API as appropriate.
- **All** payments for each NPI or API must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803
804-270-7027 or 888-335-8476 (Fax)

Electronic Funds Transfer Application

GENERAL INFORMATION

_____
Provider Name

_____
Remittance Address City State Zip

Authorization Agreement for Automatic Deposits (CREDITS)

I hereby authorize ACS and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following Provider ID:

NPI or API as appropriate	Tax ID Number

Printed Name **Title**

Signature **Date**

This authorization is to remain in full force until ACS or the financial institution has received written notification from me and/or ACS of its cancellation in a timely manner so as to afford ACS and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

☐ **Electronic remittance request (835):**

I certify that I have authorized Service Center _____ to receive my electronic remittances (835) and that Service Center must have prior approval from ACS to receive such electronic remittances. I also understand that I will continue to receive paper remittances **only** for the time period selected below after the electronic remittances start. **(If no time frame is selected below, the default is 60 days.)**

☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days

☐ I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center _____ effective on _____ for my 835s.

☐ **Claims Status Request/Response (276/277):**

I certify that I have authorized Service Center _____ to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services.

* IF YOU DO NOT QUALIFY FOR A NPI AND ARE REQUESTING A NEW API IN YOUR ENROLLMENT PACKET, LEAVE THE NPI/API NUMBER BLANK AND IT WILL BE FILLED IN BY PROVIDER ENROLLMENT AFTER THE API IS ASSIGNED.

PROVIDER NAME		NPI/API NUMBER
SIGNATURE	**DATE**	**TELEPHONE NUMBER**
PRINTED NAME		**TITLE**

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PO Box 26803
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