COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

HCBCS - AIDS Case Management

VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents your application will be processed. Processing of your application may take up to 10 business days. Completed paper Enrollment Applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax numbers or address.

Toll free 888-335-8476 or 804-270-7027 (Fax)

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application you can contact Provider Enrollment Services at toll-free 1-888-829-5373 or local 1-804-270-5105.

Contents:

- Enrollment Form Instructions - Please read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Please make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

ENROLLMENT FORM INSTRUCTIONS

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. Atypical Provider Identifier (API) and National Provider Identifier (NPI)

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 as that qualify them as a healthcare provider according to the HIPAA rules. If this is the case enter your 10-digit NPI. If you are a business, enter your organization (Type 2) NPI. If you are an individual, enter your individual (Type 1) NPI.

To participate as a provider of medical or health services for the Commonwealth of Virginia Department of Medical Assistance Program (DMAS), you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. Therefore, you are required to obtain an NPI to participate in Medicaid and other DMAS programs even if you do not use electronic transactions.

Please note that while an NPI may be associated with multiple service locations, DMAS is requiring the following set of primary information to be unique for an NPI:

- Provider Name
- Mail-To Address
- Pay-To Address
- Remittance Advice Address
- Electronic Funds Transfer (EFT) Account Number
- TIN/SSN for Tax/1099 purposes
- Service Center/Receiver for electronic transactions sent to you by Virginia Medicaid

2. Organization Name

Enter an organization name. Organizations are enrolled under IRS Name or Doing Business as (DBA) name.

3. Primary Servicing Address (Required)

Enter your Primary Servicing Address in this section. Please use Addendum A - Additional Servicing Location Information if enrolling provider for more than one Serving Location.

- A Post Office Box address is not acceptable as a service location.
- Your email address is required in order to receive important Medicaid information via our blast email system.

NOTE: AIDS Case Management providers must be located within the Commonwealth of Virginia. Out-of-state providers are not eligible for this Virginia Medical Assistance Program.

4. Correspondence Address (Required)

Enter the address to which you would like correspondence (manual updates, Medicaid memos, etc.) sent. A Post Office Box is acceptable.

- Only one Correspondence Address is allowed per NPI.
- Your email address is required in order to receive important Medicaid information via our blast email system.

5. Pay-To Address (Optional)

Enter the address to which you would like payments for services rendered sent. If this section is left blank, payments will be sent to the Remittance Advice address. If the Remittance Advice Address is blank, payments will be sent to Primary Servicing Address.

- Only one Pay-To Address is allowed per NPI.
- Please provide your email address in order to receive important Medicaid information via our blast email system.

ENROLLMENT FORM INSTRUCTIONS

6. Remittance Advice Address (Optional)

Enter the address to which you would like Remittance Advice for services rendered sent. If this section is left blank, Remittance Advices will be sent to the Pay-To Address. If the Pay-To Address is blank, payments will be sent to Correspondence Address.

- Only one Remit Advice Address is allowed per NPI.
- Please provide your email address in order to receive important Medicaid information via our blast email system.

7. IRS Name

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

8. Taxpayer Identification Number (TIN) and Effective Date

Enter your Taxpayer Identification Number (TIN), and date in which your TIN was obtained.

9. Doing Business As (DBA)

Enter the name under which the business or operation is conducted and presented to the community. This name will be used on the Virginia Medicaid provider directory search engine.

10. Requested Effective Date of Enrollment

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

The default begin date for providers located within the Commonwealth of Virginia, or within 50 miles from the Virginia border, will be the first day of the month prior to the date of your signature on the participation agreement.

11. Type of Applicant

Indicate the Type of Applicant: Corporation, Group Practice, Individual, Limited Liability Company, or Partnership.

Corporation is defined as a legal entity or structure under the authority of the laws of a state consisting of a person or group of persons who become shareholders.

Group Practice is defined as multiple fee-for-service practitioners that are paid under one Group Practice NPI.

Individual is defined as a single practitioner operating under his/her own SSN or TIN.

Limited Liability Company is defined as a business structure allowed by state statute whose owners have limited personal liability for the debts and actions of the Limited Liability Company.

12. Signature Waiver:

Signature Waiver allows for the submission of claim(s) which will contain the provider’s computer generated, stamped, or typed signature instead of original signature.

ENROLLMENT FORM INSTRUCTIONS

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY

This section must be completed by an authorized representative. An authorized representative 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.

13. Ownership and Control Information for Disclosing Entity, 42 C.F.R. §455.104

List any individual who has any ownership or controlling interest in this provider entity or in any subcontractor. List the name, title, (i.e. CEO, President), address, Tax ID (TIN) 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.

14. Relationships

List those individuals named in question 17 that are related to each other (spouse, parent, child, or sibling). Include name, relationship, and SSN.

15. Subcontractor

List any individual with an ownership or control interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

16. Other Disclosing Entity

List the name, address, and TIN of any other disclosing entity other than subcontractor 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.

17. Criminal Offenses

Has any individual or organization listed in questions 13,14, 15 and 16 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? If you check yes, please provide the name, address, SSN/TIN and percentage of ownership for individual(s) or Organization(s). 42 C.F.R. §455.106.

18. Has any individual or contractor connected with your practice 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?

If you check yes, please provide the name, address, and SSN/TIN for individual(s) or contractor(s). 42 C.F.R. §455.106.

19. 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? 42 C.F.R. §455.106

If you check yes, please provide a copy of relevant final disposition

ENROLLMENT FORM INSTRUCTIONS

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION

All Virginia Medicaid providers that enroll on or after October 1, 2011 must submit all claims electronically by Electronic Data Interchange (EDI) or Direct Data Entry (DDE), and must also enroll to receive their payments via Electronic Funds Transfer (EFT) for payment of those services. Any provider who cannot comply with the electronic claims submission requirement may request an exemption from DMAS for good cause shown. Good cause may include, but is not limited to, the unavailability of the infrastructure necessary to support electronic claims submission in the provider's geographic region, no mechanism for electronic submission for the particular claim type, or financial hardship.

Providers requesting an exemption from receiving their payments via EFT must attach justification describing why they cannot receive their payments electronically.

20. Please select if you wish to participate in the Electronic Funds Transfer (EFT) of payments directly deposited into your account.

If you select "Yes" then you must provide the following information in 21-23, if you select "No" to participate you must complete question #24 and submit supporting documentation to be considered for exemption:

21. Banking Institution – The banking institution that will be accepting your direct deposit.

22. Routing Number- Enter your banking institution 9-digit routing number.

23. Account Number- Numeric code identifying the account that will be accepting your direct deposit.

If you select "No" then you must provide the following.

24. Please select the option that describes why you are filing for an exemption from participation in EFT, and submit supporting documentation to be considered for exemption.

25. Please select if you wish to participate in Electronic Data Interchange (EDI) submission and would like a Virginia Medicaid EDI Coordinator to contact you or your Billing representative to begin the registration process for electronic claims submission and/or electronic remittance advices.

26. Please enter the name of the Billing Representative you would like a Virginia Medicaid EDI Coordinator to contact.

27. Enter contact telephone number of Billing Representative.

28. Please select if you wish to submit your claims electronically via Claims DDE through the Virginia Medicaid Web Portal.

29. Please select the option that describes why you are filing for an exemption from submitting your claim(s) electronically, and submit supporting documentation to be considered for exemption.

ENROLLMENT FORM INSTRUCTIONS

SECTION IV: HOME AND COMMUNITY-BASED CARE SERVICES DEMOGRAPHICS

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to DMAS.

30. Type of Related Experience

If organization is currently a Medicaid enrolled provider, enter in Type of Provider and valid Virginia Medicaid Provider Identification Number.

31. Administrators Name

Name of Administrator for the organization

32. Administrative Personnel

Please provide name, title, and telephone for all persons responsible for general management of your organizations Adult Day Health Care and Private Duty Nursing Services Medicaid Program to include:

- Person responsible for signing contract
- Chief Administrator On-Site
- Other On-site Contact Person
- Chief Corporate Officer
- Other Corporate Contact Person

33. Geographical Areas

List cities and counties in which you intend to service Medicaid eligible Members.

34. Ownership Information

Enter in Name and Address of all owners of organization and percent of ownership. Percent of ownership must equal 100 percent. If your organization is a Non-Profit Organization in accordance with Section 501© (3), a list of your organizations board of director must be submitted.

35. Criminal Disclosure

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including owner, operator, manager and/or employee) associated with the organization who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider organization to make inquiry and screen individuals at the point of application for employment to comply with this section.

Has anyone associated with the organization (owner, operators, managers, or employees) been convicted of a criminal offense? If yes, please submit a copy of relevant final disposition)

ENROLLMENT FORM INSTRUCTIONS

36. Staffing Credentials

As an AIDS Case Management program provider you are responsible for assuring that all AIDS Case Management staff meets the qualifications detailed in chapter II of the Elderly or Disabled with Consumer Direction Waiver Services provider manual. All AIDS Case Management staff that performs supervisory activities must be familiar with all definitions for the completion of the functional status assessments and all program requirements, regardless of whether they perform these activities on a full or part time basis. It is the provider's responsibility to assure that any new staff for the AIDS Case Management Program is oriented to the programs policies, procedures and forms necessary to comply with DMAS requirements. The provider is also responsible for instructing all Medicaid Members of AIDS Case Management program requirements related to their performance of duties as employers.
Describe knowledge of and/or experience with developing assessments, care plans, monitoring need, receipt and accessing the services in regards to the Infectious Disease (specifically HIV) population.

37. Compliance with Federal Regulations regarding rates for services

Does an authorized administrator and signee of Participation Agreement that the chief administrative agent of organization understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services?

38. Insolvency or Bankruptcy verification

Does an authorized administrator and signee of Participation Agreement that there is neither a judgment or pending action of insolvency or bankruptcy in a State or Federal court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services?

39. Validation of program description and accurate completion of enrollment application.

Does an authorized administrator and signee of Participation Agreement that the Chief Administrative Agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services, and that all information within this application is accurate, truthful, and complete?)

40. REMARKS: Please enter any other information to be considered in addition to the information contained within your enrollment application.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. ATYPICAL PROVIDER IDENTIFIER (API) OR NATIONAL PROVIDER IDENTIFIER (NPI): _____

2. ORGANIZATION NAME: _____

3. PRIMARY SERVICING ADDRESS (Physical location where provider renders services)

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone (required) _____ Ext. _____ 24 Hour Phone _____

TDD Phone _____ Fax Number _____ E-Mail (required) _____

Contact Name _____ Contact Phone _____

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

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ E-Mail (required) _____

Do you wish to receive Medicaid correspondence at this address? ☐ Yes ☐ No

5. PAY TO ADDRESS

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ E-Mail _____

Contact Name _____ Contact Phone _____

6. REMITTANCE ADVICE ADDRESS

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ E-Mail _____

7. IRS NAME _____

8. TAXPAYER IDENTIFICATION NUMBER (TIN) _____ EFFECTIVE DATE _____

9. DOING BUSINESS AS (DBA) If other than the IRS NAME _____

10. REQUESTED EFFECTIVE DATE OF ENROLLMENT _____

11. TYPE OF APPLICANT (Please check only one)

☐ Corporation ☐ Group Practice

☐ Individual ☐ Limited Liability Company

☐ Partnership

12. SIGNATURE WAIVER:

I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.

☐ Yes ☐ No

SECTION II: OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY. 42 C.F.R. §455.104

13. List any individual who has any ownership or controlling interest in this provider entity or in any subcontractor: 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.

Name (Last, First)	Title	Address	SSN/TIN	Percent

14. Relationships: List those individuals named in question 13 that are related to each other (spouse, parent, child, or sibling). 42 C.F.R. §455.104.

Name (Last, First)	Relationship

15. Subcontractor: List any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more. 42 C.F.R. §455.104

Name (Last, First)	Title	Address	SSN/TIN	Percent

16. Other Disclosing Entity: 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 (Last, First)	Title	Address	SSN/TIN	Percent

17. Criminal Offenses: Has any individual or organization who has any 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? 42 C.F.R. §455.106

☐ No ☐ Yes if yes please provide the Name, Title, Address, SSN/TIN, and Percent of Ownership for individual(s) or organization(s).

Name (Last, First)	Title	Address	SSN/TIN	Percent

18. 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? 42 C.F.R. §455.106

☐ No ☐ Yes (if yes, please provide the Name, Address, and SSN/TIN information for the individual(s) or contractors (s) below.

Name	Address	SSN or TIN if an organization

19. 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? 42 C.F.R. §455.106

☐ No ☐ Yes (if yes, please attach a copy of any relevant final disposition documentation)

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION

20. I will participate in Electronic Funds Transfer (EFT) of payments directly deposited into my account.

- ☐ Yes (complete questions 21-23)
- ☐ Not able to participate (complete question 24 and attach supporting documentation to be considered for an exemption.

21. Banking Institution: _____

22. Routing Number: _____

23. Account Number: _____

EFT Exemption

24. I am filing for an exemption from participation in EFT for the following reasons:

- ☐ Unable to transact business through a banking institution capable of EFT
- ☐ Other reason for exemption consideration (if checked please submit supporting documentation)

Electronic Data Interchange (EDI)

25. ☐ Yes I would like to request participation in electronic claims submission and remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Please have a Virginia Medicaid Electronic Data Interchange (EDI) Coordinator contact me or my Billing Representative to start the registration process for electronic claims submission and/or electronic remittance advices.

26. EDI Billing Representative Contact Name: _____

27. EDI Billing Representative Contact Phone Number: _____

Claims Direct Data Entry (DDE)

28. ☐ I have elected to submit my claim(s) electronically via Claims Direct Data Entry through the Virginia Medicaid Web Portal.

Electronic Claims Exemption

29. ☐ I am filing for an exemption to submit my claim(s) electronically at this time for the following reasons:

- ☐ Unavailability of the infrastructure necessary to support electronic claims submission in my geographic region.
- ☐ No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid.
- ☐ Financial Hardship (if checked please submit supporting documentation)
- ☐ Other (If checked please submit supporting documentation)

_____

_____

_____

SECTION IV: HOME AND COMMUNITY-BASED CARE SERVICES DEMOGRAPHICS

In Accordance with Federal requirements, all providers of Home and Community - Based Care services must submit the following information to DMAS.

30. TYPE OF RELATED EXPERIENCE:

My organization is currently a Virginia Medicaid enrolled provider ☐ Yes ☐ No

(if yes please check type of provider and Provider ID)

Type of Provider

☐ Clinic _____ ☐ Hospital _____

☐ Home Health Agency _____ ☐ Outpatient Rehabilitation Agency _____

☐ Hospice _____ ☐ Nursing Facility _____

☐ Hospital _____

31. ADMINISTRATOR NAME _____

32. ADMINISTRATIVE PERSONNEL (at least one must complete)

Name of Person Responsible for signing contract _____

Title _____

Office Phone Number _____

Name of person you report to _____

This person is responsible for general management of requested Medicaid program(s) ☐ No ☐ Yes

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Name of Chief Administrator On-site _____

Title _____

Office Phone Number _____

Name of person you report to _____

This person is responsible for general management of requested Medicaid program(s) ☐ No ☐ Yes

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Name of Other On-site contact person _____

Title _____

Office Phone Number _____

Name of person you report to _____

This person is responsible for general management of requested Medicaid program(s) ☐ No ☐ Yes

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Name of Chief Corporate Officer _____

Office Phone Number _____

Name of Other Corporate Person _____

Office Phone Number _____

33. GEOGRAPHIC AREAS TO BE SERVED (at least one must be added)

34. OWNERSHIP NAME AND PERCENTAGE (Must equal 100 percent)

Name	Address	Percent (must equal 100)

35. CRIMINAL OFFENSE DISCLOSURE

Has anyone associated with your organization (owner, operators, managers or employees) been convicted of a criminal offense

☐ No ☐ Yes If yes, please attach a copy of relevant final disposition

36. STAFF CREDENTIALS

Case Manager Name

Type of Degree/Major course of study

Describe knowledge of and/or experience with the Infectious Disease (specifically HIV) population

Case Manager reports to

Other Case Manager Responsibilities

Case Manager participates in provision, authorization or oversight of any direct services? ☐ No ☐ Yes

37. I certify as authorized administrator that the chief administrative agent of organization understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services.

☐ Yes

38. I certify as authorized administrator that there is neither a judgment or pending action of insolvency or bankruptcy in a State or Federal court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

☐ Yes

39. I certify as authorized administrator that the Chief Administrative Agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services, and that all information within this application is accurate, truthful, and complete.

☐ Yes

40. REMARKS: Please limit to 500 characters.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
Medical Assistance Program

HCBCS - AIDS Case Management Participation Agreement

This is to certify:

Provider Name _____

NPI _____

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 is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.
3. 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 federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. 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 will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. 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 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.
11. Except as otherwise provided by applicable state or 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.
12. 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.
13. 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.

For Virginia Medicaid use only

Director, Division of Program Operations Date

Original Signature of Provider Date