COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Mental Health Services

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 ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

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 toll-free at 1-888-829-5373 or local 1-804-270-5105.

Contents:

- Enrollment Form Instructions - Read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.
- Application Fee Submission Form - Applicable fee is submitted with the enrollment application.

ENROLLMENT FORM INSTRUCTIONS

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. National Provider Identifier (NPI) (Required)

If your organization is enrolling for the services listed below enter your organization's NPI. To participate as a provider of medical or health services for the Department of Medical Assistance Services (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. More information about the NPI and how to obtain one can be found at http://www.cms.gov under Regulations and Guidance, HIPAA Administrative Simplification, National Provider Identifier Standard (NPI).

2. Organization Name (Required)

Enter the organization name which identifies your organization to the public. This name will be used on the Virginia Medicaid Provider Search Directory.

3. Primary Servicing Address (Required)

Enter your Primary Servicing Address in this section.

- A Post Office Box address is not acceptable as a service location.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.

4. Correspondence Address (Required)

Enter the address to which you would like correspondence (Medicaid Manual updates, Medicaid memos, etc.) sent.

- A Post Office Box is acceptable for this type of address.
- Indicate whether or not you want Medicaid correspondence sent through the United States Post Office to this address.
- Only one Correspondence Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Correspondence Address is the same as the Primary Servicing Address, write SAME on the Attention line.

5. Pay To Address (Optional)

Enter the address to which you would like payments sent for services rendered.

- Only one Pay To Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Pay To Address is the same as the Correspondence Address, write SAME on the Attention line.

6. Remittance Advice Address (Optional)

Enter the address to which you would like Remittance Advice sent for services rendered.

- Only one Remittance Advice Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Remittance Address is the same as the Pay To Address, write SAME on the Attention line.

7. IRS Name (Required)

Enter the IRS name associated with the tax ID registered with the IRS.

8. Taxpayer Identification Number (TIN) (Required)

Enter your nine-digit Taxpayer Identification Number (TIN). This may also be called your Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification Number (FTIN).

9. Doing Business as (DBA) Name (Optional)

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 Search Directory.

10. Requested Effective Date of Enrollment (Required)

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

- Effective date cannot be more than one year past the current date.
- Effective date will never be before the effective date of your license.

11. Mental Health Services and License (Required)

Select service you are applying to provide and for which you are licensed. Choose the license type, and enter the license number, effective date and end date.

- **Behavioral Therapy under Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Outpatient Mental Health program.
- **Crisis Intervention -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Outpatient Mental Health program.
- **Crisis Stabilization -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Outpatient Mental Health program with a Crisis Stabilization track or Residential Crisis Stabilization.
- **Day Treatment for Children and Adolescents -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Day Treatment Program.
- **Day Treatment for Pregnant Women -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a:
  - Outpatient Mental Health Program
  - Residential Substance Abuse Program
  - Substance Abuse Day Treatment
- **Day Treatment Partial Hospitalization -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Day Treatment Program.
- **Intensive Community Treatment -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a
  - Assertive Community Treatment Program
  - Intensive Community Treatment Program
- **Intensive In-Home -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Intensive In-Home Services.
- **Mental Health (MH) Case Management -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Intensive In-Home Services.
  - Only Community Services Board (CSB) are eligible for this program
- **Mental Health Support Services -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a
  - Assertive Community Treatment
  - Intensive Community Treatment
  - Supportive In-Home Services
- **Mental Retardation (MH/MR) Case Management -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Intensive In-Home Services.
  - Only Community Services Board (CSB) are eligible for this program

- **Crisis Stabilization -** Providers of this Mental Health service must be licensed through one or more of the following license boards:

  - Board of Pharmacy
  - Center for Substance Abuse (SA) Treatment
  - Drug Enforcement Agency (DEA) Administrative License

- **Psychosocial Rehabilitation -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a

  - Clubhouse Services Program
  - Day Support Program
  - Psychosocial Rehabilitation Program

- **Residential Treatment for Pregnant Women -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Residential Substance Abuse (SA) Program.

- **Substance Abuse Case Management -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Substance Abuse Case Management Services.

- **Substance Abuse Crisis Intervention -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Outpatient Mental Health Program.

- **Substance Abuse Day Treatment -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as a Day Treatment Services Program

- **Substance Abuse Intensive Outpatient -** Providers of this Mental Health service must be licensed through the Department of Behavioral Health and Developmental Services (DBHDS) as an Intensive Outpatient Services Program.

12. Mental Health Clinics License and Required Documents (Required)

Select service you are applying and are licensed, enter number, effective and end dates.

- Providers of this Mental Health service must be licensed through DBHDS.
- Providers of this service must complete Provider Screening and Application Fee Section of this application.

13. Type of Applicant (Required)

Indicate the Type of Applicant: Corporation, 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.
- 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.
- Partnership is defined as the relationship existing between two or more persons who join and carry on a trade or business.

14. Languages Other Than English Spoken at Practice (Optional)

Select all that apply for languages that are spoken at your organization. If no language is selected, English only will be recorded.

15. Signature Waiver (Required)

Signature waiver allows for the submission of claim(s) which will contain the provider's computer generated, stamped, or typed signature instead of a hand written signature.

16. Provider Screening (Required for Mental Health Clinics)

If you are enrolling as an out of state provider you are required to be previously screened by CMS or by the Medicaid program that is located in the same state as your servicing address. If you have not been previously screened by one of the entities mentioned above, then you are not eligible to enroll in Virginia Medicaid and your application will be rejected upon receipt.

Select if your organization has been screened in the last twelve months by a Medicaid agency or Medicare, is in the process of being screened or has not been screened.

- If your organization has been screened by Medicare in the last twelve months, enter the date the screening was completed. This information will be confirmed.
- If your organization has been screened by another state's Medicaid program in the past twelve months, enter the state and the date the screening was completed. This information will be confirmed.
- Select the appropriate option if screening is in process with Medicare or another state's Medicaid program, but has not been completed. If the screening is in process by another state's Medicaid program enter the state.
- If you have not begun the screening process, choose the fourth option and continue to the next question.

17. Application Fee (Required for Mental Health Clinics)

If your organization has submitted a fee to Medicare or another state's Medicaid agency, but has not yet been screened, select one of the next two options and enter the date paid and to whom the fee was paid. Continue to Section II.

If you have not been screened by or paid a fee to Medicare or another state's Medicaid agency you will be required to select one of the final four choices.

- Make a payment to Virginia Medicaid. Prior to submission of this application you will have an option to choose your method of payment. See the Application Fee Form at the end of this Application.
- Submit a hardship exception request to Virginia Medicaid. Attach a letter to this application describing your request. The letter should be on letterhead, signed by an authorized person, dated, and include your NPI.
- Submitted a hardship exception request to Medicare and it is in-process. Attach a copy of your request to this enrollment application.
- Was granted approval for a hardship exception request by Medicare. Attach a copy to this enrollment application.

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104 AND 42 C.F.R. §455.106

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.

18. Ownership and Control Information for Disclosing Entity (Required)

List any managing employee and/or any individual(s) or organization(s) who has any ownership or controlling interest in this provider entity or in any subcontractor. The term “managing employee” means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Type of ownership (owner, controlling interest, managing employee or other)
- Address
- Percentage of ownership

If your organization is a non-profit or not-for-profit organization in accordance with IRS Section 501(c)(3):

- Enter 501(c)(3) under ownership
- Attach a list of your board of directors, including first name, last name or organization name, title (i.e. CEO, President), date of birth, SSN for individuals or Tax ID (TIN) for organizations, and address.

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

19. Relationships (Required)

List those individuals named in the previous question who are related to each other.

Include:

- Name from previous question
- Relationship, (spouse, parent, child, or sibling)
- Name of the person from previous question to whom they are related

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

20. Subcontractors (Required)

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

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

21. Other Disclosing Entity (Required)

List the name, title, SSN/TIN, address and percentage of ownership 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.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

22. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)

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

Criminal offenses that must be included are:

- Convictions for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

Include:
- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

23. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)

If you check Yes, list any individual or contractor connected with your practice that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct.

Criminal offenses that must be included are:

- Conviction for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

Include:
- First and last name or organization name
- Date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

24. Adverse Legal Actions (Required)

Check Yes if the applicant has had any adverse legal actions imposed by:

- Medicare
- Medicaid
- Federal agency or program
- Any state's agency or program
- Any licensing or certification agency

If Yes, attach a copy of the final disposition.

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION

All Virginia Medicaid providers that enroll must submit all claims electronically by Electronic Data Interchange (EDI) through a clearing house, or Direct Data Entry (DDE) through the Virginia Medicaid web portal (www.virginiamedicaid.dmas.virginia.gov). Providers must also enroll to receive their payments via Electronic Funds Transfer (EFT) for payment of those services. Any provider who cannot comply with these requirements for good cause must request an exemption describing why they cannot comply.

25. Electronic Funds Transfer (Required)

If you select “Yes” to participate in the Electronic Funds Transfer (EFT) of payments directly deposited into your account, you must provide:

- The account type that will receive your EFT deposits
- The name of the financial institution that will receive your EFT deposits
- The routing or ABA number of the financial institution above. Your banking institution’s 9-digit routing number is sometimes called the ABA number. The routing number must begin with numbers that fall in the ranges 01-12, 1-32 or 61-72 (for example 079986597). Note the number on your deposit slip is not a valid routing number. Attach a voided check or ask your financial institution for a letter and attach a copy
- The account number is a code identifying the account that will be accepting your direct deposit

If you select “No”, you must apply for an exemption and show good cause.

- Good cause may include, but is not limited to the unavailability of a banking institution capable of transacting business via EFT.
- To apply for an exemption, attach to this application either a letter from the financial institution or a letter from the applicant for consideration. The letter must:
  - Be on letterhead, either a financial institution's or the applicant's
  - Be signed
  - Be dated
  - Include the applicant’s NPI
  - Include a description of the good cause

26. Electronic Claims Submission (Required)

For more information on how to submit claims through Electronic Data Interchange (EDI) through a clearing house or through Direct Data Entry (DDE) for no cost on the Virginia Medicaid Web Portal, visit www.virginiamedicaid.dmas.virginia.gov. This information is located in the Quick Links menu, Provider Services, EDI Support.

- Select “Yes” if you will submit claims using (EDI) through a clearing house or DDE through the Virginia Medicaid Web Portal, www.virginiamedicaid.dmas.virginia.gov.
- If you select “No", you must apply for an exemption and show good cause.
  - Good cause may include, but is not limited to:
    - Unavailability of necessary infrastructure in the geographic region
    - No mechanism to electronically submit for a particular claim type
    - Financial hardship
  - To apply for an exemption, attach a letter to this application for consideration. The letter must:
    - Be on the applicant’s letterhead
    - Be signed
    - Be dated
    - Include the applicant’s NPI
    - Include a description of the good cause

27. Electronic Remittance Advice (ERA) (Optional)

Select "Yes" if you would like to request participation in electronic remittance advices as part of your enrollment with Virginia Medicaid and FAMIS and enter the Service Center Name and ID Number.

28. Remarks (Optional)

Enter any additional information you would like to be considered as part of your enrollment application.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. **National Provider Identifier (NPI) (Required)** _____

2. **Organization Name (Required)** _____

3. **Primary Servicing Address (Required)**

Attention _____

Address _____ _____ _____ _____

Street City State Zip

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

TDD Phone _____ Fax Number _____ Email (Required) _____

Contact Name _____ Contact Phone _____

4. **Correspondence Address (Required)**

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email (Required) _____

Do you want to receive mailed Medicaid correspondence to this address? ☐ Yes or ☐ No

5. **Pay To Address (Optional)**

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email _____

Contact Name _____ Contact Phone _____

6. **Remittance Advice Address (Optional)**

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email _____

7. **IRS Name (Required)** _____

8. **Taxpayer Identification Number (TIN) (Required)** _____

9. **Doing Business as (DBA) Name (Optional)** _____

10. **Requested Effective Date of Enrollment (Required)** _____

11. Mental Health Services and License (Required)

Choose the service(s) you wish to provide and enter the license information for each. Attach a copy of the license if indicated. Acronyms are defined in the Instructions.

☐ **Behavioral Therapy under EPSDT**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Crisis Intervention**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Crisis Stabilization**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Day Treatment Children and Adolescents**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Day Treatment for Pregnant Women**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Day Treatment Partial Hospitalization**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Intensive Community Treatment**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Intensive In-Home**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Mental Health Case Management – (CSBs Only)**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Mental Health Support Services**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Mental Retardation Case Management – (CSBs Only)**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Opioid Treatment**

Select all licenses that apply and enter the license number, effective date and end date.

☐ Board of Pharmacy

License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ Center for Substance Abuse (SA) Treatment

License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ Drug Enforcement Agency (DEA)

License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Psychosocial Rehabilitation**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Residential Treatment for Pregnant Women**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Substance Abuse Case Management**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Substance Abuse Crisis Intervention**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Substance Abuse Day Treatment**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ **Substance Abuse Intensive Outpatient**

DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

12. Mental Health Clinic (Required)

☐ DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach Copy)

☐ Provider Screening and Application Fee Sections of this application complete (Required)

13. Type of Applicant - Check Only One (Required)

☐ Corporation ☐ Limited Liability Company

☐ Partnership

14. Languages Other Than English Spoken - Check All That Apply (Optional)

☐ Farsi ☐ Hindi ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other: _____

15. Signature Waiver ☐ Yes ☐ No (Required)

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

16. Provider Screening (Required for Mental Health Clinics)

Select one of the following:

☐ I have been screened by Medicare in the last 12 months. Date Approved: _____

☐ I have been screened by another state Medicaid Agency in the last 12 months.

State: _____ Date Approved: _____

☐ Screening is currently in process by Medicare or another state Medicaid Agency.

State: _____

☐ I have not yet been screened by Medicare or another state Medicaid Agency

17. Application Fee (Required for Mental Health Clinics)

☐ I have paid an application fee in the past 12 months.

☐ I have paid an application fee to Medicare within the last 12 months.

Date Paid: _____

☐ I have paid an application fee to another state Medicaid agency within the past 12 months.

State: _____ Date Paid: _____

☐ I have not paid an application fee in the past 12 months.

☐ I will pay the application fee to Virginia Medicaid - see Application Fee Submission Form at the end of application.

☐ I am submitting a Hardship Exception Request. Attach request to application.

☐ I have submitted a Hardship Exception Request and it is in-process. Attach a copy to application.

☐ I have received an approved Hardship Exception Request letter from CMS. Attach a copy to application.

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104. AND 42 C.F.R. §455.106.

18. Ownership and Control Information for Disclosing Entity (Required)

List any managing employee and/or any individual(s) or organization(s) that has any ownership or controlling interest in this provider entity. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement.

List the Individual Name or Organization Name, Title (i.e. CEO, MD, Pres.), Date of Birth, SSN/Tax ID (TIN), Type of Ownership, Address and Percentage of Ownership The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

19. Relationships (Required)

List those individuals named in the previous question who are related to each other (spouse, parent, child, or sibling) and whom they are related to.

Name Listed Above _____
Relationship (i.e. spouse, parent, child, or sibling) _____
Is Related to (Name) _____

Name Listed Above _____
Relationship (i.e. spouse, parent, child, or sibling) _____
Is Related to (Name) _____

Name Listed Above _____
Relationship (i.e. spouse, parent, child, or sibling) _____
Is Related to (Name) _____

Name Listed Above _____
Relationship (i.e. spouse, parent, child, or sibling) _____
Is Related to (Name) _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

20. Subcontractors (Required)

List the Name, Title, Date of Birth, SSN/TIN, Address and Percentage of Ownership for any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

21. Other Disclosing Entity (Required)

List the name, title, Date of Birth, SSN/TIN, Percent Ownership and Address 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.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

22. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)

Has any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare 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 Name, Title, Date of Birth, Address, and SSN/TIN information for individual(s) or organization(s). Attach copy of the final disposition.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual or organization.

23. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)

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 is excluded from any Federal or State healthcare 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 Name, Date of Birth, Address, and SSN/TIN information for the individual(s) or contractors below. Attach a copy of the final disposition.

Name/Organization _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____
Date of Birth _____ SSN/TIN _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed attach additional paper listing all of the required information for the additional individual or organization.

24. Adverse Legal Actions (Required)

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other Federal or State agency or program, or any licensing or certification agency.

☐ No ☐ Yes If Yes, attach a copy of any final disposition documentation.

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION (Required)

25. Electronic Funds Transfer (Required)

☐ Yes, I will participate in EFT of payments directly deposited into my financial account. Complete the following:

Account Type ☐ Checking ☐ Savings ☐ Other

Name of Financial Institution _____

Routing or ABA number _____

Account Number _____

☐ No, I am filing for an exemption from participation in EFT for good cause.

☐ I am attaching a letter from my financial institution stating the inability of the institution to transact business using EFT.

☐ I am attaching a letter describing my good cause for exemption.

26. Electronic Claims Submission (Required)

☐ I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS.

☐ I am requesting an exemption from filing 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. If checked attach supporting documentation.

☐ No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid. If checked attach supporting documentation.

☐ Financial Hardship. If checked, attach supporting documentation.

☐ Other: _____

To be considered for an exemption, attach supporting documentation.

27. Electronic Remittance Advice (ERA) (Optional)

☐ Yes, I would like to request participation in electronic remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Complete the following:

Service Center Name _____

Service Center ID Number _____

28. Remarks (Optional)

_____

_____

_____

_____

_____

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
Medical Assistance Program

Mental Health Services 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 upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. 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

APPLICATION FEE SUBMISSION FORM

An application fee is required to enroll in the Virginia Medicaid Program for certain providers. To determine whether your applicant is required to submit a fee, refer to the last question in Section I.

The application fee is $542. This fee must be paid and clear our financial institution prior to the processing of your enrollment application.

Provider Name _____ NPI _____

To Pay by Check:

- Make the check payable to **Department of Medical Assistance Services.**
- The amount of the payment is **$542.00.**
- Write your NPI on the Memo line of the check to ensure it will be credited to your application.
- Write the check number here: _____.
- Include this form with the rest of the enrollment application and send to:

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

To Pay by Credit Card:

- Paying by credit card is quick and easy.
- Provide your credit card information below:

o Mark the type of credit card you are paying with:

☐ Master Card ☐ Visa ☐ Discover ☐ American Express

o Credit Card Number:

_____ - _____ - _____ - _____

o Card Expiration Date

Month: _____ Year: _____

o Security Code: _____

- For Visa, Master Card and Discover, the three digit security code is found on the back as shown in the image on the left.
- For American Express the four digit security code is found on the front as shown in the image on the right.

o Name on the Credit Card: _____

o Billing Address:

Street_____ Suite_____

City _____ State _____ Zip_____