INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™
PROVIDER ENROLLMENT FACILITY/AGENCY APPLICATION

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Instructions

1. Enter the complete name of the facility/agency.

2. Check the appropriate box for the action(s) requested:
   a. Initial Enrollment - This service location (address) is not actively enrolled on the provider file and needs added/reactivated
   b. Revalidation - This service location (address) is currently active on the provider file and needs updated per ACA regulations
   c. Indicate the Provider's Medicaid ID number if known.

3. Enter the assigned National Provider Identifier (NPI) Number and taxonomy code(s):
   - Valid DHS taxonomies are listed in the "Provider Type/Provider Specialty to Taxonomy Crosswalk" at http://www.dhs.pa.gov/provider/nationalprovideridentifiernpiinformation/index.htm
   - Attach an additional sheet if there are more than four (4) taxonomies for this location
   - If your provider type does not require use of a NPI, please leave this field empty

4. Enter the requested effective date for the action request.

5. Enter the provider type number and description (e.g. - Number: 06; Description: Hospice).

6. Enter the Specialty/Sub Specialty - See the requirements document for the provider type:
   a. Enter the PRIMARY Specialty Code/Description and Sub-Specialty Code (if applicable) (e.g. - Specialty Code: 060; Description: Hospice; Sub Specialty Code: N/A)
   b. Enter additional Specialty/Description and Sub-Specialty codes (if applicable)

7. Enter the Name and Tax Identification Number (TIN) as registered with the IRS.
   a. Enter the TIN as assigned by the IRS
   b. Enter the legal name as it is registered with the IRS
   c. Include a legible copy of a document generated by the IRS showing the Name and IRS number of the entity applying for enrollment – W-9s are not accepted

8. Check the appropriate box to indicate whether or not the provider plans to participate with any MCOs and list the MCOs.

9. Check the appropriate box to indicate whether or not the business operates under a Fictitious Name and enter the Fictitious Name and permit number.

10. Enter the IRS/Legal Entity contact information:
    a. Enter the address where the 1099 tax documents from PA Medical Assistance should be sent
    b. Enter the name and title of the person who should be contacted regarding the 1099 tax documents
    c.-f. Enter the requested information for the contact listed in 10a and 10b.

11. Check the appropriate box for the business type of the entity applying for enrollment:
    a. Include a legible copy of the incorporation papers or business partnership agreement (if applicable)

12. Enter the facility's license number, issuing state, issue date and expiration date (if applicable).
    a. Include a legible copy of the license

13. Enter the facility's Drug Enforcement Agency (DEA) Number (if applicable).
    a. Include a legible copy of the DEA certificate

14. Check the appropriate box to denote whether there is a CLIA/Laboratory Permit associated with this service location.
    a. Include a legible copy of the CLIA certificate and PA Department of Health Clinical Laboratory Permit
    b. Out-of-State providers must submit a copy of their home state laboratory licensure (if applicable)

15. Enter the CMS Certification number (if applicable).

16. a. Indicate whether this facility is recognized as a Rural Health Clinic or Federally Qualified Health Center.
    b. If the facility is a RHC or FQHC, indicate what services it provides. Remember to attach a copy of the most recent HRSA grant letter with this application.

17. Enter the physical address of the service location. The address must be a physical location - **NOT** a post office box - **Please note: All addresses will be geocoded per the US Postal Service (**https://tools.usps.com/go/ZipLookupAction!input.action**)**
    a. Check the appropriate boxes for handicap accessibility
    b. Check the appropriate boxes to denote if this location also bills for services provided in a mobile unit
    c. Check the appropriate boxes to denote if this location has been enrolled, credentialed and/or revalidated by one of the listed entities within the last 12 months
    d. Check the appropriate boxes to denote if this address should also be used as the Home Office, Mail To and/or Pay To address

18. Check the appropriate box to indicate whether or not the provider wishes to receive Medical Assistance Bulletins via email:
    a. If yes, list the email address where bulletins should be sent
        - By answering "NO" the provider is agreeing to be responsible to check for new MABs by visiting http://www.dhs.pa.gov/publications/bulletinsearch/index.htm

          – OR –

          by signing up to receive notifications through the MA Electronic Bulletins Listserv

19. Check this box if the provider wants claims from Medicare to crossover to this service location address.
    a. **Please note**: Only **one** service location per NPI number can be designated as the crossover location.

20. Enter the contact information for issues/questions about **this** application.

21. Check the appropriate box to indicate whether staff can communicate in a language other than English.
    a. If yes, list the language(s) in which staff can communicate

22. Enter the Provider Eligibility Program(s) (PEP) under which the provider plans to provide services - See PEP descriptions on the Department of Human Services Provider Enrollment website in the Additional Forms section and the requirements document for the provider type and the provider's requirements document.

23. Confidential Information:
    a. The representative of the facility applying for enrollment must complete ALL confidential Information questions (A-E).

b. If answering "Yes" to any of the questions, provide a detailed explanation on a separate piece of paper and attach it to the application - Refer to the Confidential Information page for the information that must be included in the explanation.

24. Sign the application and print your name, title and the date (the signature should be that of someone able to represent the facility or agency applying for enrollment) - **Use black ink.**

25. Enter Mail-To/Pay-To/Home Office Information:
    a. This page may be used to add a Mail-To, Pay-To and/or Home Office address to the previously listed service location address listed in Question 16.
    b. **PLEASE NOTE: This page cannot be used to add additional service location addresses** - Please complete a separate application for each additional service location address that needs enrolled.

26. Complete and sign the Provider Agreement.

27. Ownership & Control Interest:
    a. Section I - This section must be completed by all providers
    b. Section II - This section should be completed by any entity that is formed as a corporation, partnership, estate trust or government entity (regardless of for-profit/non-profit status)
    c. Section III - This section should ONLY be completed by non-profit entities that are not formed as a corporation
    d. **NOTE: Once enrolled, sign up for the Electronic Funds Transfer Direct Deposit Option by following the link below: http://www.dhs.pa.gov/provider/electronicfundstransferdirectdepositinformation/index.htm**

When completed, review the "Did You Remember…?" Checklist included with the application.

PROMISe™ PROVIDER ENROLLMENT FACILITY/AGENCY APPLICATION

1. Enter Name of Facility/Agency:

_____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment

b. ☐ Revalidation or Reactivation

c. ☐ Check here if previously enrolled in Medical Assistance (MA)

Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

3. National Provider Identifier Number: _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy: _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy: _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

4. Requested Effective Date:
yyyy / mm / dd – (2004/07/31)

_ _ _ _/_ _/_ _

5. Provider Type Number and Description:

Number: ___ ___

Description: _____

6. Provider Specialty/Sub-Specialty:

i.Specialty: ___ ___ ___ Description: _____ Sub-Specialty: ___ ___ ___
Code Code

ii.Specialty: ___ ___ ___ Description: _____ Sub-Specialty: ___ ___ ___
Code Code

7a. Federal Tax ID Number:

___ ___ ___ ___ ___ ___ ___ ___ ___ (9 digits)

A legible copy of a document generated by the IRS showing the legal name and FEIN is required for for the application to be processed.

7b. Legal Name Shown on IRS Document:

_____

8a. Does the provider intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

8b. If so, list the MCO(s):

_____

_____

9a. Does the provider operate under a Fictitious Name?

☐ Yes ☐ No

9b. If "yes", list the Statement/Permit number and the name:

Number: _____

Name: _____

A legible copy of the recorded/stamped fictitious business name statement/permit is required for this application to be processed.

10a. IRS Address: **Note**: **This is the address where the 1099 tax document will be sent.**

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _ _ _ _ _-_ _ _ _ **(9 digits)**

10b. Contact Name/Title:

Name: _____

Title: _____

10c. Contact E-mail Address:

_____

10d. Contact Phone:

( )

10e. Contact Toll-Free Phone:

( )

10f. Contact Fax Number:

( )

11. Business Type: (Check **1** Box Only)

☐ Business Corporation, For Profit
☐ Estate/Trust
☐ Government Owned
☐ Not For Profit
☐ Partnership
☐ Public Service Corporation
☐ Sole Proprietorship

12. a. License Number: _____ b. Issuing State: _____

c. Issue Date: _____ d. Expiration Date: _____

A copy of the provider's license is required for the application to be processed.

13. Drug Enforcement Agency (DEA) Number: _____

If the provider has a DEA number, a copy of the DEA certificate is required for this application to be processed.

14. Are a CLIA certificate and a Dept. of Health Lab Permit associated with this Service Location? ☐ Yes ☐ No

If "yes", please provide a copy of both with this application.

Please note: Out-of-state providers rendering laboratory services must also have a Clinical Laboratory Permit issued by the PA Department of Health. Additional information can be found at: http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Laboratories/Pages/Lab%20Improvement/Laboratory-Improvement.aspx#.WxGgJKPD-M8

15. CMS Certification number: _____

16a. Is this application for an active Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC)? ☐ Yes ☐ No

Please note that a copy of the HRSA grant letter must be included with this application.

16b. If "yes", please indicate the services provided:

☐ Medical Services Only ☐ Dental Services Only ☐ Both Medical and Dental Services

17. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _ _ _ _ _-_ _ _ _ **(9 digits)** County: _____

Business Phone: ( ) _____ - _____ Fax Number: ( ) _____ - _____

a. Handicap Accessibility

i. Does the office have exterior or interior steps leading to the main entrance doorway?
Yes ☐ No ☐ Exterior ☐ Interior ☐

ii. If the answer to (i) is yes, does the office have a permanent or portable wheelchair ramp?
Yes ☐ No ☐ Permanent ☐ Portable ☐

iii. If the answer to (i) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes ☐ No ☐
No exterior steps ☐ No interior steps ☐
Permanent ramp ☐ Portable ramp ☐

b. Does the provider bill for a mobile unit from this location?

i. Mobile Medical Unit? ☐Yes ☐ No
ii. Mobile Dental Unit? ☐Yes ☐ No

c. Has the provider named in Block 1 been screened for this location within the last 5 years by:

i. Medicare? ☐ Yes ☐ No
ii. Children's Health Insurance Program (CHIP)? ☐ Yes (Complete below) ☐ No
iii. Another state's Medicaid program? ☐ Yes (Complete below) ☐ No

_____ _____ _____
Screening State | Screening Contact Phone Number | Screening contact email address

d. Check all applicable boxes. This service location is also a: ☐ Pay-to ☐ Mail-to ☐ Home Office

If Pay-to, Mail-to, and/or Home Office are different from above address, refer to question 25.

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18. a. Would the provider like to receive E-mail notification of new bulletins? Yes ☐ *No☐

b. E-mail Address to which MA bulletins should be sent: _____

*By answering **"no",** the provider is agreeing to be responsible to check for new MABs by visiting the following website: http://www.dhs.pa.gov/publications/bulletinsearch/ **OR** by signing up to receive notifications of new MABs through the MA Electronic Bulletins Listserv

If requesting to continue receiving paper bulletins call 1.800.537.8862 options 3,1,1,4 to see if the requirements are met.

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19. Check this block only if requesting Medicare claims to crossover to this service location. ☐

20a. Contact Name: _____ Title: _____ **This is the contact name and phone number we will use if we have any questions about this application.**	20b. Contact Phone: ( )

20c. Contact Toll-Free Phone: ( )	20d. Contact Fax Number: ( )	20e. Contact E-mail Address:

21a. In addition to English, does staff communicate with patients in another language? Yes ☐ No ☐	21b. If "Yes", list language(s): _____ _____

22. Provider Eligibility Program (PEP): See PEP descriptions available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/form/c_202856.pdf and the requirements document for the provider type. **Choose at least 1 PEP.**

a. _____ b. _____ c. _____

23. **CONFIDENTIAL INFORMATION**
Have you, any agent or managing employee ever:

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

☐ Yes ☐ No

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

☐ Yes ☐ No

C. Had a controlled drug license withdrawn?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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

24. This form requires the original signature of the authorized agent or representative of the provider

_____ _____
Title Printed Name

_____ _____
Original Signature Date

25. Mail-To/Pay-To/Home Office Information For The Service Location Entered In 17

NOTE: Do not use this sheet to add service locations.

a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

c. E-mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
( )

f. Toll-Free Phone
( )

g. Fax Number:
( )

a. **Address:** Street Suite/Box City State Zip (**9-digits)** County

b. This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

c. E-mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
( )

f. Toll-Free Phone
( )

g. Fax Number:
( )

a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

c. E-mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
( )

f. Toll-Free Phone
( )

g. Fax Number:
( )

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Provider Agreement for Outpatient Providers

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

_____

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

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

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

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

4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.

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

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

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

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

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

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

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

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

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

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

_____ _____

(Provider – Original Signature) **(Date)**

_____

(Name – Please Type or Print)

THIS SPACE INTENTIONALLY LEFT BLANK

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure Forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR, Part 455, Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

Other Disclosing entity means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b. Any Medicare intermediary or carrier; and

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity.

b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.

d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

e. Is an officer or director of a disclosing entity that is organized as a corporation; or,

f. Is a partner in the disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means**:**

a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

OWNERSHIP AND CONTROL INTEREST DISCLOSURE

Note: Ownership and Control Interest information is required in accordance with the Federal Regulations at 42 CFR, Part 455.

Name of disclosing entity: _____

13-digit PROMISe™ Provider Number: _____

Contact Name (for questions on this form): _____

Contact Phone: (_____) _____ - _____ Contact E-mail Address: _____

Section I: Managing Employee or Agent Disclosure

A. Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the disclosing entity.

The following individual is a: ☐ **Managing Employee** ☐ **Agent**

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP) or a state health care program?

   ☐ **Yes (Provide details below)** ☐ **No**

2. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION I A TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

Section II: Ownership and Control

If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

A. Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

☐ **Direct:** _____% ☐ **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. If the individual listed above is an officer or director, what position does the individual hold?

☐ **President** ☐ **Chairman** ☐ **Member**
☐ **Vice President** ☐ **Vice Chairman**
☐ **Secretary** ☐ **Director**
☐ **Treasurer** ☐ **Officer**

2. a. Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____ Relationship: _____

Section II: (cont.)

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____ Relationship: _____

Attach separate sheet, if necessary

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

4. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

5. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS****

Section II: (cont.)

CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

B. Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

   ☐ **Direct:** _____% ☐ **Indirect:** _____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

   Address: _____ Suite/Apt: _____

   _____ _____ _____ _____
   (City) (State) (Zip Code) (+4)

   Attach separate sheet, if necessary

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____

   Address: _____ Suite/Apt: _____

   _____ _____ _____ _____
   (City) (State) (Zip Code) (+4)

   Attach separate sheet, if necessary

****COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

C. Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

   ☐ **Direct:** _____% ☐ **Indirect:** _____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

   ☐ **Direct:** _____% ☐ **Indirect:** _____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

   e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

Section II: (cont.)

f. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

g. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS****

D. Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

☐ **Direct:** _____% ☐ **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

☐ **Direct:** _____% ☐ **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

E. Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

   ☐ **Direct:** _____% ☐ **Indirect:** _____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II E TO ADD ADDITIONAL SUBCONTRACTORS OF THE DISCLOSING ENTITY****

OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES

F. Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II F TO ADD ADDITIONAL ENTITIES****

SIGNIFICANT BUSINESS TRANSACTIONS

G. Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

☐ **Yes (Provide details below)** ☐ **No**

Name of Supplier/Subcontractor: _____

Social Security Number or Federal Tax ID: _____ Date of Birth: _____
(Individuals only)

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II G TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)

If the disclosing entity is a non-profit organized as a corporation, please complete Section II

A. Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. What position is held by the individual listed above?

☐ **President**	☐ **Chairman**	☐ **Member**
☐ **Vice President**	☐ **Vice Chairman**	
☐ **Secretary**	☐ **Director**	
☐ **Treasurer**	☐ **Officer**	

2. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XX (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS****

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and submit it with this application. Incomplete applications will be returned.
Please do not staple any documents as the application will be scanned.

Did you remember to…?

- ❑ **USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.**
- ❑ **Complete all spaces** as required on the application with either the correct information or N/A.
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ If there are more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- ❑ Indicate ***one* primary** provider type, provider specialty and sub-specialty, as applicable.
- ❑ Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- ❑ Include incorporation papers from the Department of State Corporation Bureau or a copy of the business partnership agreement, if applicable.
- ❑ If applicable, **include a copy** of the:
  - ❑ Professional license
  - ❑ CLIA certificate
  - ❑ Clinical Lab Permit issued by the Department of Health
  - ❑ DEA Certificate
  - ❑ Mammography certificate, including the list of mammography certified members and their PROMISe™ 13 digit provider numbers.
  - ❑ Any other certification, license, or permit
- ❑ Enter **at least 1** Provider Eligibility Program (PEP).
- ❑ Show proof of home state Medicaid participation (out-of-state providers only).
- ❑ Only the **representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

When completed, review the "Did You Remember…?" Checklist included with the application. Return the application and other documentation TO THE ADDRESS LISTED ON THE REQUIREMENTS FOR THE SPECIFIC PROVIDER TYPE. If no address is listed on the requirements for the specific provider type/specialty, please mail to:

DHS Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045
Fax: (717) 265-8284
E-mail: RA-ProvApp@pa.gov