TMHP Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Portal Ticket #: xxxxxxxx
Date Printed: Thursday, September 10, 2020
NPI: xxxxxxxxx
Provider Name: Name of School

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs

Application Type Identification

Please select all the programs you would like to enroll in:

- [x] Traditional Medicaid
- [ ] THSteps Medical — For more information about the Texas Health Steps Medical program, click here.
- [ ] CSHCN Services Program — For more information about the Children with Special Health Care Needs (CSHCN) Services Program, click here.
- [ ] THSteps Dental — For more information about the Texas Health Steps Dental (Oral Health) program, click here.
- [ ] Medical Transportation Program (MTP)
- [ ] Ordering or Referring-Only Provider

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs: Provider Type Identification Form

Click here for more information

Provider Type Identification

Applicant is enrolling as: ○ Individual ○ Performing Provider ○ Group ◉ Facility

☐ I understand that in the future if I wish to seek reimbursements for services performed to Medicaid recipients I must submit a new enrollment application to be eligible for Medicaid billing.

Are you using a Medicare certification number for this enrollment? ○ Yes ◉ No To access the Medicare Number Required Provider List Click here.

Do not continue with this application if your Medicare certification number is pending.

☑ **I understand that the services that are provided to Medicare-eligible clients cannot be billed to Medicaid unless Medicare is billed first. If the services are not billed to Medicare first, Medicaid may recoup payments for the services. I also understand that I cannot bill the client for these services.**

NPI/API: XXXXXXXXXX
Please click Verify NPI to validate the NPI you are enrolling against NPPES data.

If you do not have an NPI, choose a provider type: - select -
If the appropriate Provider Type is not available, you are not eligible to enroll as an A-Typical Provider.

Traditional Services

- ☐ Ambulance/Air Ambulance
- ☐ Ambulatory Surgical Center (ASC)
- ☐ Anesthesiologist Assistant (AA)
- ☐ Audiologist
- ☐ Birthing Center
- ☐ Catheterization Lab
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Chemical Dependency Treatment Facility
- ☐ Chiropractor
- ☐ Clinic/Group Practice
- ☐ Community Mental Health Center
- ☐ Comprehensive Health Center (CHC)
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Consumer Directed Services Agency (CDSA)
- ☐ Dentist
- ☐ Durable Medical Equipment (DME)
- ☐ Family Planning Agency
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Federally Qualified Look-alike (FQL)
- ☐ Federally Qualified Satellite (FQS)
- ☐ Freestanding Psychiatric Facility
- ☐ Freestanding Rehabilitation Facility
- ☐ Genetics
- ☐ HCSSA
- ☐ Hearing Aid
- ☐ Home Health
- ☐ Hospital - In-State
- ☐ Hospital Ambulatory Surgical Center (HASC)
- ☐ Hospital - Military
- ☐ Hospital - Out-of-State
- ☐ Hyperalimentation
- ☐ Independent Diagnostic Testing Facility
- ☐ Independent Lab (Physician Involvement)
- ☐ Independent Lab (No Physician Involvement)
- ☐ Indian Health Services (IHS)
- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Marriage and Family Therapist (LMFT)
- ☐ Licensed Midwife
- ☐ Licensed Professional Counselor (LPC)
- ☐ Maternity Service Clinic (MSC)
- ☐ Medical Transportation Program (MTP)
- ☐ Milk Bank Donor
- ☐ Nurse Practitioner/Clinical Nurse Specialist
- ☐ Occupational Therapist (OT)
- ☐ Opioid Treatment Provider (OTP)
- ☐ Optician
- ☐ Optometrist (OD)
- ☐ Orthotist
- ☐ Outpatient Rehabilitation Facility (ORF)
- ☐ Personal Assistant Services
- ☐ Pharmacist
- ☐ Pharmacy Group
- ☐ Physical Therapist (PT)
- ☐ Physician (DO)
- ☐ Physician (MD)
- ☐ Physician Assistant
- ☐ Physiological Lab
- ☐ Podiatrist
- ☐ Portable X-Ray
- ☐ Prosthetist
- ☐ Prosthetist-Orthotist (Choose if licensed as both)
- ☐ Psychologist
- ☐ Qualified Rehabilitation Professional
- ☐ Radiation Therapy Center
- ☐ Radiological Lab
- ☐ Renal Dialysis Facility
- ☐ Respiratory Care Practitioner
- ☐ Rural Health Clinic - Hospital, Freestanding
- ☐ Skilled Nursing Facility
- ☐ Specialized/Custom Wheeled Mobility
- ☐ Speech-Language Pathologist (SLP)
- ☐ State Supported Living Center (SSLC)
- ☑ SHARS - School, Co-Op or School-based health center
- ☐ Service Responsibility Option (SRO)
- ☐ TB Clinic
- ☐ Vision Medical Supplier (VMS)

☐ I certify my practice is limited to individuals' birth through 20 years of age. I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled.

☐ I certify that the service(s) I render is/are not recognized by Medicare for reimbursement. I further certify the claims for these services will not be billed to Medicare (this includes Medicare crossover claims). I understand if Medicare certification is obtained during or after the completion of the Texas State Health-Care Programs enrollment application, I will be required to submit a new enrollment application listing this Medicare certification information. Performing providers cannot request a Medicare Waiver when joining a group that is Medicare enrolled.

In the box below, explain and justify your reasons for making a Medicare Waiver Request.

Case Management Services

- ☐ Early Childhood Intervention (ECI)
- ☐ MH Case Management - LMHA
- ☐ IDD Case Management - LIDDA
- ☐ MH Rehabilitative Services - LMHA
- ☐ MH Case Management/MH Rehabilitative Services - Non-LMHA
- ☐ Case Management for Children and Pregnant Women (CPW)
- ☐ Blind Children's Vocational Discovery & Development Program
- ☐ Women, Infants & Children (WIC) - Immunization Only
- ☐ Youth Empowerment Services (YES) Waiver
- ☐ Home and Community Based Services - Adult Mental Health

Comprehensive Care Services (CCP)

- ☐ Dietitian
- ☐ Licensed Vocational Nurse
- ☐ Occupational Therapist (OT-CCP)
- ☐ Pharmacy
- ☐ Physical Therapist (PT-CCP)
- ☐ Prescribed Pediatric Extended Care Center
- ☐ Registered Nurse
- ☐ Speech-Language Pathologist (SLP-CCP)

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs: Provider Type Specific

Need more information?

- Are you a private or public person/entity? ○ Private ◉ Public

Facilities Only:

- Is this a freestanding facility? ◉ Yes ○ No
- Is this a hospital-based facility? ○ Yes ◉ No
- Is this an ESRD facility? ○ Yes ◉ No
- If yes, what is your composite rate?

School Health and Related Services (SHARS) Providers Only:

If enrolling as a special education co-op, send a list of all school districts in the co-op that will be providing SHARS services. Provide the following information for each school district.

- Complete address
- School District Number
- T.E.A. Number

- Are you enrolling as a school district? ◉ Yes ○ No
- If yes, give school six-digit T.E.A. number. XXXXXX

Public/ Non-Public Providers (Required by all providers):

Definition: Public providers are those that are owned or operated by a city, state, county, or other government agency or instrumentality, according to the Code of the Federal Regulations, including any agency that can do intergovernmental transfers to the State. Public agencies include those that can certify and provide state matching funds.

- If public entity, are you required to certify expended funds? ◉ Yes ○ No

Address

In Care of Name: NAME

Street: ADDRESS

Suite:

City: CITY

State: Texas

ZIP Code: ZIP

Validate Address

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs: Provider Specialty/Taxonomy

Click here for more information **You are required to complete this screen for every provider type that you are enrolling per Enrollment guidelines.**

Program: Traditional Medicaid
Services: SHARS - School, Co-Op or School-based health center

Please select your taxonomies

TMHP has reviewed and assigned all taxonomy codes that reflect services that are a benefit of the Texas State Programs. The taxonomy codes that are listed are specific to the services rendered by the provider type and specialty that you have chosen.

If you are enrolling as a group you will be asked to assign a taxonomy code for the group TPI and each of the performing providers in the group. The group TPI will have the taxonomy code that describes either a multi specialty or single specialty group. The performing provider will have a choice of taxonomy codes specific to the services rendered for the provider.

Specialty: **Clinic/Group Practice**

Sub-Specialty: **PUBLIC PROVIDER**
(If applicable)

Available Codes:

Click here to view Taxonomy definitions from the Washington Publishing Company.

Primary Taxonomy Code: **XXXXXXX**

Secondary Taxonomy Codes:
(Maximum 15 codes allowed)

Enter Texas Non-Enrolled Taxonomy Code:

All letters in taxonomies must be capitalized.

This button will enable after clicking "Retrieve Taxonomies" above.

Texas Non-Enrolled Taxonomy Codes:
(Maximum of 5 Codes Allowed)

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs: Provider Demographics

Click here for more information

Existing Medicaid Texas Provider Identifiers (TPIs):
(Please list all other assigned Texas Medicaid TPIs)

Existing TPIs

Group or Facility Name: **Name of School**

Employer's Tax I.D. Number: **xxxxxxxxx**

Business Name/Doing Business As:

Legal Name According to the I.R.S.: **Legal Name**
(Identical to W-9)

Email Address 1: **Email**

Provider Business Web Site Address:

Email Address 2:

Delivery Notification
You will be notified of application deficiencies by e-mail unless you choose to receive the paper notification by mail. Choosing to opt out of receiving a notification will increase your overall processing time on your application. TMHP strongly encourages you to receive enrollment notifications via email.

Communication Preference

I prefer to receive notifications by: (•) Email ( ) Mail

Physical Address:
(Where services are rendered to clients and to be included and displayed in the Online Provider Lookup)

Street: **ADDRESS**
Suite:
City: **CITY**
State: **Texas**
ZIP Code: **ZIP**

Same as physical address

Accounting / Billing Address:
(Where provider information is to be sent)

Street: **ADDRESS**
Suite:
City: **CITY**
State: **Texas**
ZIP Code: **ZIP**

Phone Number: **xxx-xxx-xxxx** ext.

Fax Number:

Business Fax Number:

If your accounting address is different from your physical address, please indicate your relationship to the Accounting Address:

( ) Third Party Biller ( ) Management Company ( ) Employer
( ) Self ( ) Other (Specify)

Select a reason for applying to join Texas State Health-Care Programs: **Not Applicable**

Surety Bond

Accepting New Clients? (•) Yes ( ) No

Gender Limitations: **Both**

Counties Served: **COUNTY**

Client Age Restrictions: **0** TO **21**

Are you enrolling to provide services exclusively to clients in the Childrenâ€™s Health Insurance Program (CHIP)? ( ) Yes (•) No

I would like my provider information to be visible on the Texas Medicaid Online Provider Lookup (OPL). ( ) Yes ( ) No

Provider Enrollment : Application for Texas Medicaid and other state healthcare programs: Substitute W-9 Taxpayer Identification

Click here for more information

Substitute Form W-9:
Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

NAME OF SCHOOL

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited Liability Company. Enter the tax classification (C=Corporation, S=S corporation, P=partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☑ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

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

ADDRESS

6 City, state, and ZIP code

CITY, TX ZIP

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN).

Note: If the account is in more than one name, see the instructions for line 1. Also see What Name and Number To Give the Requester for guidelines on whose number to enter.

Social Security Number

or

Employer Identification Number

XXXXXXXX

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number; and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person; and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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

☐ Check here to cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

☑ I attest this is what appears on my W-9.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

☐

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Provider Information Form (PIF-1)

Click here for more information

Social Security Number:

Employer's Tax ID: XXXXXXXX

Specialty of Practice:
(Example: Pediatrics, General Practice, etc) Clinic/Group Practice

Professional License/Certification/Accreditation

Add...

CLIA Address:

Street:

Suite:

City:

State:

ZIP Code:

Previous Physical Address

Street:

Suite:

City:

State:

ZIP Code:

Same as previous physical address

Previous Account / Billing Address

Street: ADDRESS

Suite:

City: CITY

State: Texas

ZIP Code:

Do you plan to use a Third Party Biller to submit your Medicaid claims? Yes No

If yes, provide the following information about the billing agent:

Billing Agent Name: NAME

Tax ID Number: XXXXXXXX

Contact Person Name: NAME

Telephone Number: xxx-xxx-xxxx Ext.

Street Address: ADDRESS

Suite:

City: CITY

State: Texas

ZIP Code: ZIP

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/Atypical Provider Identifier (API) or TPI of each Provider or entity:

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contact cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

Have you ever been sanctioned (as defined above) in any state or federal program? Yes No

If yes, fully explain the details, including date, the state where the incident occurred, the agency taking the action and the program affected.

Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions? Yes No

Have you ever had your professional healthcare license or certification revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions? Yes No

Have you ever voluntarily surrendered (a) professional healthcare license or certification in lieu of disciplinary action? Yes No

If yes was answered to any of the questions, fully explain the details including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license:

- Have you ever enrolled in or applied to any other State's Medicaid or CHIP program? ○ Yes ◉ No
- Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any state or federally funded program? ○ Yes ◉ No
- Do you currently have any outstanding debt or have you received notice of an unpaid amount due in relation to any State or Federally funded program? ○ Yes ◉ No

If yes was answered to any of the questions, fully explain the details including date, and the state if applicable.

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Provider Information Form (PIF - 1) Continued

Click here for more information

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?

To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. (You may be subject to a criminal history check.)

Convicted means that:

(a) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

- There is a post-trial motion or an appeal pending, or
- The judgement of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

○ Yes ◉ No

Have you been arrested for a crime but not yet charged or is there an outstanding warrant for arrest?

○ Yes ◉ No

If yes, provide the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:

Country of Citizenship **COUNTRY**

If you did not answer "United States of America" above, send a copy of your green card, visa or other documentation demonstrating your right to reside and work in the United States.

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Electronic Funds Transfer

Click here for more information

Instructions

Electronic Funds Transfer (EFT) is a payment method used to deposit funds directly into a providerâ€™s bank account. These funds can be credited to either checking or savings accounts, if the providerâ€™s bank accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks by *ensuring funds are directly deposited into a specified account.*

The following items are specific to EFT:

- Pre-notification to your bank occurs on the weekly cycle following the completion of enrollment in EFT.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both the provider identifiers (i.e., NPI, TPI, API) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Thursday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customerâ€™s withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution, who in turn should work out the best way to serve their customerâ€™s needs.

In all cases, credits received should be posted to the customerâ€™s account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

Important: *Submit the completed Electronic Funds Transfer (EFT) Notification form with a copy of a voided check or signed letter from your bank. Call the* ***TMHP Contact Center*** *at* ***1-800-925-9126*** *if you need assistance.*

Return this form to:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, TX 78720-0795

By submitting a signed copy of the EFT Notification form I agree to the following:

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

As part of the EFT enrollment process and to comply with the Affordable Care Act CAQH CORE Rule 370, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements. These data elements will allow you to easily associate your EFT payment with the appropriate ERA remittance advice. You may read more about the CAQH CORE Rule at the CAQH website: **http://caqh.org/**

Note: Complete all sections below and send a voided check or a signed letter from your bank on bank letterhead.

☐ I do not wish to participate in the EFT program

Provider Information

Provider Name	**Name of School**
Doing Business as Name (DBA)	
Provider Address	
Street	**ADDRESS**
City	**CITY**
State/Province	**Texas**
ZIP Code/Postal Code	**ZIP**
Country Code	**US - United States**

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	**XXXXXXXXX**	Provider License Number	
National Provider Identifier (NPI)	**XXXXXXXXXX**	License Issuer	

Provider Type	**School Health and Related Services (SHARS) individual**	Provider Taxonomy Code	**XXXXXXXXX**

Other Identifiers

Assigning Authority	**Medicaid**	Trading Partner ID	
Other Identifier			

Add Other Identifier

Provider Contact Information

Show Provider Contact Information

Provider Contact Name	**Name of School**		
Title			
Telephone Number	**xxx-xxx-xxxx**	Telephone Number Ext.	
Email Address	**EMAIL**		
Fax Number			

Provider Agent Information

Show Provider Agent Information

Provider Agent Name	**NAME**	Provider Agent Contact Name	**NAME**

Provider Agent Address

Street	**ADDRESS**	Title	
City	**CITY**	Telephone Number	**xxx-xxx-xxxx**
State/Province	**Texas**	Telephone Number Extension	
ZIP Code/Postal Code	**ZIP**	Email Address	**EMAIL**
Country Code	**US - United States**	Fax Number	

Federal Agency Information

Show Federal Agency Information

Federal Program Agency Name	
Federal Program Agency Identifier	
Federal Agency Location Code	

Retail Pharmacy Information

Show Retail Pharmacy Information

Pharmacy Name	**NAME**	Chain Number	
Parent Organization ID		Payment Center ID	
NCPDP Provider ID Number		Medicaid Provider Number	

Financial Institution Information

Financial Institution Name	**BANK NAME**	Financial Institution Routing Number	**XXXXXXXXX**

Financial Institution Address

Street	**ADDRESS**	Type of Account at Financial Institution	**1. Checking**
City	**CITY**	Provider's Account Number with Financial Institution	**XXXXXXXXXX**
		Account Number Linkage to Provider Identifier	
State/Province	**Texas**	Provider Tax Identification Number (TIN)	**XXXXXXXXX**
		National Provider Identifier (NPI)	**XXXXXXXXXX**
ZIP Code/Postal Code	**ZIP**		
Financial Institution Telephone Number			
Telephone Number Extension			

A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Submission Information

Reason for Submission	New Enrollment / Change Enrollment / Cancel Enrollment		
Include with Enrollment Submission	Voided Check / Bank Letter		
Authorized Signature			
Electronic Signature of Person Submitting Enrollment		Printed Name of Person Submitting Enrollment	
Written Signature of Person Submitting Enrollment		Printed Title of Person Submitting Enrollment	

Submission Date	2020/09/10	Requested EFT Start Date	2020/10/01

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Principal Information Form (PIF-2)

Click here for more information

Select person or entity:
(•) Person ( ) Entity

Select principal or subcontractor:
(•) Principal ( ) Subcontractor

Owner

Last Name: NAME
Maiden Name:
First Name: NAME
Other Alias or Nicknames ever used:
Middle Initial:
Percent Owned: 100.00%

Address

Physical Address:

Street: ADDRESS
Suite:
City: CITY
State: Texas
ZIP Code: ZIP

Accounting / Billing Address:

[x] Same as physical address

Street: ADDRESS
Suite:
City: CITY
State: Texas
ZIP Code: ZIP

Accounting Address Relationship

If your accounting address is different from your physical address, please indicate your relationship to the accounting address:

( ) Third Party Biller ( ) Management Company
( ) Employer ( ) Self
( ) Billing Agent ( ) Other

Professional Healthcare Licensing Information

Professional Licensing State:
Professional License Number:
Professional Licensing Board:
Professional License Issue Date: mm/dd/yyyy
Professional License Expiration Date: mm/dd/yyyy
Social Security Number: XXXXXXXXX
Federal Tax ID:
Specialty of Practice: **(Example: Pediatrics, General Practice, etc.)**

Do you have one or more professional healthcare licenses, accreditations, or certifications? ( ) Yes (•) No

License/Certification/Accreditation

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Principal Information Form (PIF-2) Continued

Click here for more information

Driver's License Number ○ Other Number

Driver's License or Other Number: XXXXXXXX

Driver's License or Other Expiration Date: MM/DD/YYYY

State Issuer: Texas

Date of Birth: MM/DD/YYYY

Gender: ○ Male ◉ Female

Previous Physical Address

Street:

Suite:

City:

State:

ZIP Code:

☐ Same as previous physical address

Previous Accounting/Billing Address

Street:

Suite:

City:

State:

ZIP Code:

Your title in the provider organization for which enrollment is being sought:

Special Education Director

Your duties to the provider organization:

Having both content and instructional expertise the coach works as a colleague with SPED teachers to support student learning and teacher practice. Focuses on individual and group professional learning that will expand and refine the understanding of research-based effective instruction for teachers. Provides personalized 1:1 support based on the goals and identified needs of individual teachers. Promotes the mission and vision of the district.

Your role in the provider organization:

	Role	Effective Date
○	JOB TITLE	MM/DD/YYYY

Edit This Item | Delete This Item

Do you have a relationship with a separate provider?

○ Yes ◉ No

Please explain relationship with separate provider.

List all TPIs, provider names, and physical locations under which you have billed or in which you were a principal. Include current and previous TPIs.

List all medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each entity.

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.

Have you ever been sanctioned (as defined above) in any state or federal program?

○ Yes ◉ No

If yes, fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected.

Is your professional healthcare license or certification currently revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?

○ Yes ◉ No

Have you ever had your professional healthcare license or certification revoked, suspended or otherwise restricted, which includes all disciplinary and non-disciplinary actions?

○ Yes ◉ No

Have you ever voluntarily surrendered (a) professional healthcare license or certification in lieu of disciplinary action?

○ Yes ◉ No

Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State

or Federally funded program?
Yes No

Do you currently have any outstanding debt or have you received notice of an unpaid amount due in relation to any State or Federally funded program?
Yes No

If yes was answered to any of the questions, fully explain the details including the date, state, name of the board or agency (if applicable), any adverse action against your license (if applicable) and details of outstanding debt or settlement agreements (if applicable).

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Principal Information Form (PIF-2) Continued

Click here for more information

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)?

To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described below, and which includes deferred adjudications and all other types of pretrial diversion programs. (You may be subject to a criminal history check.)

Convicted means that:

(a) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

- There is a post-trial motion or an appeal pending, or
- The judgement of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgement of conviction has been withheld.

○ Yes ◉ No

Have you been arrested for a crime but not yet charged or is there an outstanding warrant for arrest?
○ Yes ◉ No

If yes, fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of:

Are you currently subject to court ordered child support payments?
○ Yes ◉ No

Are you currently behind 30 days or more on court ordered child support payments?
○ Yes ◉ No

If yes, provide details, including date, the state and county where the incident occurred, the cause number(s), and specifically what you were convicted of:

Are you a citizen of the United States?
◉ Yes ○ No

If no, of what country are you a citizen? **COUNTRY**

Provider Enrollment: Application for Texas Medicaid and other state healthcare programs: Disclosure of Relationship Form

Click here for more information

Please disclose any of the following familial relationships between principals and/or the provider:
Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling.

Relationships

☑ There are no known relationships.

HHSC Medicaid Provider Agreement (Traditional Medicaid)

Click here for more information

Name of Provider

Last Name:	**Name of School**	TPI Number:	
First Name:		Medicare Provider ID Number:	
Middle Initial:			

Physical Address		**Accounting/Billing Address** (if applicable)	
Street	**ADDRESS**	Street	**ADDRESS**
Suite		Suite	
City	**CITY**	City	**CITY**
State	**Texas**	State	**Texas**
ZIP Code	**ZIP**	ZIP Code	**ZIP**

Please read the agreement below, select "Yes" or "No" to each question, then check "I Agree."

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the Provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

The current *Texas Medicaid Provider Procedures Manual* (Provider Manual) may be accessed via the internet at www.tmhp.com. Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws governing or regulating Medicaid, and provider further acknowledges and agrees that the provider is responsible for ensuring that all employees and agents of the provider also comply. Provider agrees to acknowledge HHSC's provision of enrollment processes and authority to make enrollment decisions as found in Title 1, Part 15, Chapter 352 of the Texas Administrative Code. Provider is specifically responsible for ensuring that the provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to waste, abuse and fraud, and provider acknowledges and agrees that the provider and its principals will be held responsible for violations of this Agreement through any acts or omissions of the provider, its employees, and its agents. For purposes of this Agreement, a principal of the provider includes all owners with a direct or indirect ownership or control interest of five percent or more, all corporate officers and directors, all limited and non-limited partners, and all shareholders of a legal entity, including a professional corporation, professional association, or limited liability company. Principals of the provider further include managing employee (s) or agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

1.2 State and Federal regulatory requirements.

1.2.1 By signing this Agreement, Provider certifies that the provider and its principals have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the provider and its principals have also not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any other state or federal health-care program. Provider must notify the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC §1320a-7), which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 48 CFR, Ch. 3, relating to eligibility for federal contracts and grants.

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 CFR Part 455, Subpart B, and provide such information on request to the Texas Health and Human Services Commission (HHSC), Department of State Health Services (DSHS), Texas Attorney General's Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, provider licensure, certification, or accreditation, phone number, or provider business addresses. Changes due to a change of ownership or control interest must be reported to HHSC or its designee within 30 days of the change. All other changes must be reported to HHSC or its designee within 90 days of the change.

Provider agrees to disclose all convictions of Provider or Provider's principals within ten business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Send the information to the Texas Health and Human Services Commission's Office of Inspector General, P.O. Box 85211 – Mail Code 1361, Austin, Texas 78708. Fully explain the details, including the offense, the date, the state and county where the conviction occurred, and the cause number(s).

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, Texas Department of Family and Protective Services (DFPS), the Texas Department of State Health Services (DSHS) and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital based rural health clinics); or, until all investigations are resolved and closed, or audit exceptions are resolved; whichever period is longest. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1667. Provider understands and agrees that payment for goods and services under this Agreement is conditioned on the existence of all records required to be maintained under the Medicaid program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If provider fails to create, maintain, or produce such records in full accordance with this Agreement, provider acknowledges, agrees, and understands that the public monies paid the provider for the services are subject to 100 percent recoupment, and that the provider is ineligible for payment for the services either under this Agreement or under any legal theory of equity.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit,the Texas Health and Human Services Commission's Office of Inspector General, and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, subcontractors, and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this Agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its agents, employees and subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the Texas Health and Human Services Commission's Office of Inspector General or its designee. Subcontractors include those persons and entities that provide medical or dental goods or services for which the Provider bills the Medicaid program, and those who provide billing, administrative, or management services in connection with

Medicaid- covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Medicaid recipients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Medicaid program for Medicaid recipients and discounted services to the general public must not be billed to Medicaid for a Medicaid recipient as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent is not eligible to receive the specified grant, loan, or payment. (3) If HHSC is informed and verifies that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

1.2.8 Cost Report, Audit and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and encounter data.

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or other appropriate payer, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by HHSC or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by a Health Maintenance Organization or Insurance Payment Assistance.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by HHSC for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that HHSC is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a client or any financially responsible relative or representative of the client for Medicaid covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR §447.20).

1.3.5 As a condition of eligibility for Medicaid benefits, a client assigns to HHSC all rights to recover from any third party or any other source of payment (42 CFR §433.145 and Human Resources Code §32.033). Except as provided by HHSC's third-party recovery rules (*Texas Administrative Code* Title 1 Part 15 Chapter 354 Subchapter J), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services (42 CFR §447.15).

1.3.6 Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct and are received by HHSC or its agent, and to implement an effective method to track submitted claims against payments made by HHSC or its agents.

1.3.7 Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund any overpayments, duplicate payments and erroneous payments that are paid to Provider by Medicaid or a third party as soon as any such payment is discovered or reasonably should have been known.

1.3.8 TMHP EDI and Electronic Claims Submission. Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, and receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic R&S report. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to HHSC or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

1.3.9 Reporting Waste, Abuse and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the Texas Health and Human Services Commission's Office of Inspector General. To report waste, abuse or fraud, go to **www.hhs.state.tx.us** and select "Reporting Waste, Abuse, or Fraud". Individuals may also call the Office of Inspector General hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet.

II. ADVANCE DIRECTIVES – HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

(a) The individual's right to self-determination in making health-care decisions;

(b) The individual's rights under the Natural Death Act (Health and Safety Code, Chapter 166) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;

(c) The individual's rights under Health and Safety Code, Chapter 166, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

(d) The individual's rights to execute a Durable Power of Attorney for Health Care under the Probation Code, Chapter XII, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the client has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult clients on the provider's policies concerning the client's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

(a) School health and related services (SHARS)

(b) Case management for blind and visually impaired children (BVIC)

(c) Case management for early childhood intervention (ECI)

(d) Service coordination for intellectual and developmental disabilities (IDD)

(e) Service coordination for mental health (MH)

(f) Mental health rehabilitation (MHR)

(g) Tuberculosis clinics

(h) State hospitals

IV. CLIENT RIGHTS

4.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

4.3 The client must have the right to choose any qualified provider of family planning services.

V. THIRD PARTY BILLING VENDOR PROVISIONS

5.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within five working days of the initiation and termination of the contract and submitted in accordance with Medicaid requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Providers failure to provide timely notice.

5.2 Provider must have a written contract with any person or entity for the purpose of billing provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. The contract must be signed and dated by a Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according with the Medicaid records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

(a) Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Medicaid program.

(b) Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings.

(c) Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to recipients.

(d) Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Medicaid or its contractor.

(e) Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program.

(f) Biller agrees to enroll and be approved by the Medicaid program as a Third Party Billing Vendor prior to submitting claims to the Medicaid program on behalf of the Provider.

(g) Biller and Provider agree to notify the Medicaid program within five business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

VI. TERM AND TERMINATION

6.1 If the correspondence/notice of enrollment from HHSC or its agent states a termination date, this Agreement terminates on that date with or without other advance notice of the termination date.

6.2 Provider may terminate this Agreement by providing at least 30 days written notice of intent to terminate.

6.3 HHSC has grounds for terminating this Agreement, including but not limited to, the circumstances listed below, and which may include the actions or circumstances involving the Provider or any person or entity with an affiliate relationship to the Provider:

(a) the exclusion from participation in Medicare, Medicaid, or any other publically funded health-care program;

(b) the loss or suspension of professional license or certification;

(c) any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program;

(d) any circumstances indicating that the health or safety of clients is or may be at risk;

(e) the circumstances for termination listed in 42 C.F.R. § 455.416, as amended; and

(f) the circumstances for termination listed in 1 T.A.C. §371.1703, as amended.

The Provider will receive written notice of termination, which will include the detailed reasons for the termination. The written notice of termination will also inform the Provider its due process rights.

6.4 HHSC may also cancel this Agreement for reasons, including but not limited to, the following:

(a) upon further review of the Provider's application, at any time during the term of this Agreement, HHSC or its agent, determines Provider is ineligible to participate in the Medicaid program; and the errors or omission cannot be corrected;

(b) if the Provider has not submitted a claim to the Medicaid program for at least 24 months; and

(c) any other circumstances resulting in Provider's ineligibility to participate in the Medicaid program.

The Provider will receive written notification of the cancellation of the Agreement and any rights to appeal HHSC's determination will be included.

VII. ELECTRONIC SIGNATURES

7.1 Provider understands and agrees that any signature on a submitted document certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).

7.2 Provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

VIII. COMPLIANCE PROGRAM REQUIREMENT

8.1 By signing section VIII, Provider certifies that in accordance with requirement TAC 352.5(b)(11), Provider has a compliance program containing the core elements as established by the Secretary of Health and Human Services referenced in §1866(j)(9) of the Social Security Act (42 U.S.C.§1395cc(j)(9)), as applicable.

I attest that I have a compliance plan. ◉ Yes ○ No

IX. INTERNAL REVIEW REQUIREMENT

9.1 Provider, in accordance with TAC 352.5 (b)(1), has conducted an internal review to confirm that neither the applicant or the re-enrolling provider, nor any of its employees, owners, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

I attest that an internal review was conducted to confirm that neither the applicant or the re-enrolling provider nor any of its employees, owners, managing partners, or contractors have been excluded from participation in a program under the Title XVIII, XIX, or XXI of the Social Security Act. ◉ Yes ○ No

X. PRIVACY, SECURITY, AND BREACH NOTIFICATION

10.1 "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

(a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);

(b) Sensitive Personal Information (as defined in Texas Business and Commerce Code section 521.002);

(c) Federal Tax Information (as defined in IRS Publication 1075);

(d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);

(e) Social Security Administration data;

(f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

10.2 Any Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation the following:

(a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(f) OMB Memorandum M-07-16;

(g) Texas Business and Commerce Code Chapter 521;

(h) Texas Health and Safety Code, Chapters 181 and 611;

(i) Texas Government Code, Chapter 552, as applicable; and

(j) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

10.3 The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

10.4 Provider will ensure that any subcontractor of Provider who has access to HHSC Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider and Provider will submit a copy of that Business Associate Agreement to HHSC upon request.

XI PROVIDER'S BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

11.1 For purposes of this section:

Breach has the meaning of the term as defined in 45 C.F.R. §164.402, and as amended.

Discovery/Discovered has the meaning of the terms as defined in 45 C.F.R. §164.410, and as amended.

11.2 Notification to HHSC

(a) Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any unauthorized disclosure or suspected disclosure of HHSC Confidential Information to the extent and in the manner determined by HHSC.

(b) Provider's obligation begins at discovery of unauthorized disclosure or suspected disclosure and continues as long as related activity continues, until all effects of the incident are mitigated to HHSC's satisfaction (the "incident response period").

(c) Provider will require that its employees, owners, managing partners, or contractors or subcontractors (as applicable), comply with all of the following breach notice requirements.

11.3 Breach Notice:

1. Initial Notice.

(a) For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Member Information, within the first, consecutive clock hour of discovery, and for all other types of Confidential Information not more than 24 hours after discovery, *or in a timeframe otherwise approved by HHSC in writing* , initially report to HHSC's Privacy and Security Officers via email at: privacy@HHSCC.state.tx.us and to the HHSC division responsible for this UMCC;

(b) Report all information reasonably available to Provider about the privacy or security incident; and

(c) Name, and provide contact information to HHSC for, Provider's single point of contact who will communicate with HHSC both on and off business hours during the incident response period.

11.4 48-Hour Formal Notice.

No later than 48 consecutive clock hours after discovery, or a time within which discovery reasonably should have been made by Provider, provide formal notification to HHSC, including all reasonably available information about the incident or breach, and Provider's investigation, including without limitation and to the extent available:

(a) The date the incident or breach occurred;

(b) The date of Provider's and, if applicable, its employees, owners, managing partners, or contractors or subcontractors discovery;

(c) A brief description of the incident or breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);

(d) A brief description of Provider's investigation and the status of the investigation;

(e) A description of the types and amount of Confidential Information involved;

(f) Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by Provider at that time;

(g) Provider's initial risk assessment of the incident or breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHSC approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

(h) Provider's recommendation for HHSC's approval as to the steps individuals and/or Provider on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation Provider's provision of notifications, credit protection, claims monitoring, and any specific protections for a legally authorized representative to take on behalf of an Individual with special capacity or circumstances;

(i) The steps Provider has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

(j) The steps Provider has taken, or will take, to prevent or reduce the likelihood of recurrence;

(k) Identify, describe or estimate of the persons, workforce, subcontractor, or individuals and any law enforcement that may be involved in the incident or breach;

(l) A reasonable schedule for Provider to provide regular updates to the foregoing in the future for response to the incident or breach, but no less than every three (3) business days or as otherwise directed by HHSC, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

(m) Any reasonably available, pertinent information, documents or reports related to an incident or breach that HHSC requests following discovery.

11.5 Investigation, Response and Mitigation.

(a) Provider will immediately conduct a full and complete investigation, respond to the incident or breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHSC for incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC.

(b) Provider will complete or participate in a risk assessment as directed by HHSC following an incident or breach, and provide the final assessment, corrective actions and mitigations to HHSC for review and approval.

(c) Provider will fully cooperate with HHSC to respond to inquiries and/or proceedings by state and federal authorities, persons and/or incident about the incident or breach.

(d) Provider will fully cooperate with HHSC's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such incident or breach, or to recover or protect any HHSC Confidential including complying with reasonable corrective action or measures, as specified by HHSC in a Corrective Action Plan if directed by HHSC under the UCCM.

11.6. Breach Notification to Individuals and Reporting to Authorities.

(a) HHSC may direct Provider to provide breach notification to individuals, regulators or third-parties, as specified by HHSC following a breach.

(b) Provider must obtain HHSC's prior written approval of the time, manner and content of any notification to individuals, regulators or third parties, or any notice required by other state or federal authorities. Notice letters will be in Provider's name and on Provider's letterhead, unless otherwise directed by HHSC, and will contain contact information, including the name and title of Provider's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.

(c) Provider will provide HHSC with copies of distributed and approved communications.

(d) Provider will have the burden of demonstrating to the satisfaction of HHSC that any notification required by HHSC was timely made. If there are delays outside of Provider's control, Provider will provide written documentation of the reasons for the delay.

(e) If HHSC delegates notice requirements to Provider, HHSC shall, in the time and manner reasonably requested by Provider, cooperate and assist with Provider's information requests in order to make such notifications and reports.

XII ACKNOWLEDGEMENTS AND CERTIFICATIONS

12.1 By signing below, Provider acknowledges and certifies to all of the following:

(a) Provider agrees to notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy no later than ten days after the case is filed. TMHP and HHSC also request notice of pleadings in the case.

(b) Provider has carefully read and understands the requirements of this Agreement, and will comply.

(c) Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the provider information forms (PIF-1) and principal information form (PIF-2), and provider certifies that this information is current, complete, and correct.

(d) Provider agrees to review and update any information in the application to maintain compliance with and eligibility in the Medicaid program and continued participation therein.

(e) Provider agrees to inform HHSC or its designee in writing of any changes to the information contained in the application, whether such changes occur before or after enrollment. The written notification must be within 30 calendar days of any changes in the information due to a change in ownership or control interests, and within 90 days of all other changes to the information previously submitted.

(f) Provider agrees and understands that HHSC or its agent may review Provider's application any time after the application has been accepted and for the term of this Agreement. Provider agrees and understands that upon review, HHSC or its designee may determine that the information contained therein does not meet the Medicaid program enrollment requirements and Provider may no longer be eligible to participate in the Program. Provider will have the opportunity to correct any errors or omissions as determined by HHSC or its agent. Provider agrees and understands that any errors or omissions that are not corrected or cannot be corrected will result in termination of this Agreement.

(g) Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law. Fraud is a felony, which can result in fines or imprisonment.

(h) Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment, and may also result in other administrative sanctions that include payment hold, exclusion, debarment, termination of this Agreement, and monetary penalties.

(i) Provider agrees to abide by all Medicaid regulations, program instructions, and Title XIX of the Social Security Act. The Medicaid laws, regulations, and program instructions are available through the Medicaid contractor. Provider understands that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicaid.

I agree to the terms and conditions above: ☑

- **TransactionID is not available.**

Quick Links: Provider Type Identification Form | ProviderType Specific | Provider Specialty/Taxonomy | Provider Demographics | Provider Information Form | Electronic Funds Transfer | Disclosure of Ownership | Principal Information Form | Provider Acknowledgement | Signatures and Attachments

Final Acknowledgement

Application Summary

I certify that the information I have supplied in this document constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

After you accept and submit the application, you cannot make any modifications while TMHP processes it. Please use the Quick Links listed above to review the entire application before you accept and submit it.

I acknowledge that the application is complete and correct. ☐

I will use electronic signatures to complete this application ◉ Yes ○ No

After you accept and submit the application, a finalized PDF will be available in your View Messages. Please allow up to 24 hours for processing.

If you need to generate a preview PDF before you accept and submit the application, please use the following link: Generate Preview PDF The size of the enrollment application will determine the length of time that it will take to generate the preview PDF. The preview PDF will be available in your View Message when complete.

Important: Generating a preview PDF does not complete the application process. Please proceed to the Agreement section below to complete your application.

Enrollment Application Status

Application Status	PEP Ticket Number
Submitted	**xxxxxxxx**

Thank you for submitting your application to the Texas Medicaid & Healthcare Partnership (TMHP). You can check the status of your application anytime by visiting www.tmhp.com, selecting Access Provider Enrollment, and clicking View Existing Transactions.

If you have chosen to apply with Medicaid and the CSHCN Services Program at the same time, applications for both programs will be processed concurrently. You may also apply for the CSHCN Services Program once your application to Medicaid has been approved and you have received a Medicaid Texas Provider Identifier (TPI).

Print Options

You can obtain an electronic copy of your online application in 24 hours.

To print for your personal records, log onto www.tmhp.com to View Existing Transactions. Navigate to the Messages screen to locate the Portal Ticket number of the submitted application.

Online Survey on the usability of Provider Enrollment on the Portal

Online Survey

Additional Documentation

Application information must match to the W-9 information submitted.
(http://www.irs.gov/)