

**GA DEPT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Provider Enrollment Application Instructions**

A. Applicant: *Use this application if you do not have an existing Georgia Medicaid provider number.*

1. If the applicant is an individual practitioner, give the applicant's name. The practice name is optional. If you complete section 1, you will need to skip sections 2a and 2b.
- 2a. If the applicant is not an individual practitioner, give the business name. The "legal business name" is required. The "doing business as" name is optional. If you complete section 2, you should not have completed section 1. Facility Type valid values:

0 Government	1 Non-profit or Religious	2 Sole Proprietorship
3 Investor Owned	4 Public	5 Private - For Profit
6 Private - Not for Profit	8 Not Applicable	9 Other
3. This "Office Manager" information is required in order to obtain a web portal user id for members of your office staff.

B. Address Information:

1. The Office (Physical) Address is required for all providers. This is the street address from where you intend to provide services to Medicaid and/or PeachCare for Kids members. **Post office boxes are not allowed.**
2. The Mailing Address is optional. Use this field if you receive postal mail at an address other than the address provided above. Post office boxes are allowed.
3. The Pay-to Address is the address where you would like remittance advices, and other payment information, sent. This address is obtained from the W-9 form that you are required to submit.

C. Detailed Information:

1. This section should **only** be filled out by individual practitioners (those applicants that completed section A1 above).
 - a. Social security number is required.
 - b. Date of birth is required.
 - c. If you are applying to be a Georgia Better Health Care primary care physician, you are required to have either hospital admitting privileges or a formal arrangement with a physician who has hospital admitting privileges. This information should be provided on the GBHC Addendum. For all other applicants, this information is optional.
2. This information is required of applicants attempting to participate in the following categories of service: Hospital (010, 070), Swing-beds (080), Nursing Homes (110, 140, 150, 160, 170, 180).
3. This section may apply to all applicants.
 - a. This number is assigned by the Internal Revenue Service and should match the number provided on the W-9.
 - b. Enter the National Provider Identification number (if applicable)
 - c. Enter the Georgia Medicaid Payee Provider I.D. # associated with the practice, electronic funds transfer information and remit medium. Leave blank if a Payee Provider # has not been established.
 - d. Provide Medicare participation information. Your Medicare information **must** be on file if you wish to receive Medicare crossover payments.
 - e. Provide information regarding participation in other state's Medicaid programs.
 - f. Indicate any languages that are spoken at the practice location. Place a check in the box next to the primary language.

BA	Bangla	CC	Cambodian/Campuchean	CH	Chinese (Mandarin)
CZ	Czech	EN	English	FA	Farsi
FP	Filipino	FR	French	GE	German
HI	Hindi	IN	Indian	IT	Italian

JA	Japanese	KO	Korean	LA	Laotian
NA	Navajo	PO	Portuguese	RU	Russian
SA	Slavic	SL	American Sign Language	SP	Spanish
SW	Swahili	TA	Taiwanese	TU	Turkish
VN	Vietnamese	ZZ	Other		

g. Special needs valid values:

AD	Attention Disorders	AL	Allergic Disease	AR	Arthritis
AS	Asthma	CD	Cardiology	CR	Counseling Referral
DB	Diabetes	DI	Dialysis	EK	Electrocardiogram
EN	Endoscopy	ES	Emergency Services	FP	Family Planning
GE	Geriatric	GI	Gastro	HI	HIV/AIDS
HM	Holter Monitor	HY	Hypertension	LA	Laboratory
LS	Laser Surgery	MW	Mid-Wifery	NS	Norplant
OB	OB/GYN	OS	Office Surgery	UR	Urology
OX	Office X-Ray	PA	Physical Accessibility	PD	Pediatrics
PF	Pulmonary Function Test	PM	Pain Management	RH	Rheumatology
RT	Respiratory Therapy	SU	Surgery	TE	Telemedicine
TL	Telegu	OT	Other Special Needs		

h. Attach a copy of proof of liability insurance. Required for participation in Durable Medical Equipment (320), Orthotics and Prosthetics/Hearing Services (330), Ambulance Services (370, 371), and Georgia Better Health Care (850).

D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type valid values:

100	Behavioral Health & Social Ser	110	Chiropractors (Medicare Only)
120	Dentist Service Providers	130	Dietary and Nutritional Service
140	Emergency Medical Service Provider	150	Eye and Vision Providers
160	Nursing Services	170	Other Service Providers
180	Pharmacy	200	Physicians / Osteopaths
210	Podiatrists	220	Respiratory, Rehab, & Restoration
230	Speech, Language, & Hearing Se	240	Technologists, & Technicians
250	Agencies	251	Public Health Agencies
260	Ambulatory	270	Hospital Units
280	Hospital	290	Laboratories
300	Managed Care Organizations	310	Nursing Facilities
320	Residential Treatment Facilities	330	Medical Supplier
340	Transportation	360	Nurse Practitioners / Physician
370	Nursing Related Services	380	Home and Community Based Services

2. Practice Type valid values:

C	Corporation	G	Group Practice (Private)	H	Hospital Based Physician
I	Individual Practitioner	L	Public Clinics	M	Health Maintenance Org
T	Teaching Provider	R	Pre-Paid Group Practice Plan	P	Partnership / Professional Assoc
N	Not Applicable	O	Other		

3. Categories of Service valid values:

740	Advanced Nurse Practitioners	660	Independent Care Waiver Services
670	Ambulatory Surg / Birthing Center	230	Independent Laboratory
910	Childbirth Education Program	820	Licensed Clinical Social Worker - Medicare Only
960	Children's Intervention, School Based	680	Mental Retardation Waiver Program
840	Children's Intervention Services	480	Nurse Midwifery
560	Chiropractics - Medicare Only	170	Nursing Facilities, Int Care-Stated Owned-MR
590	Community Care Services	180	Nursing Facility, Int Care for MR
681	Community Habilitation and Support	160	Nursing Facilities, Intermediate Care
440	Community Mental Health Services	150	Nursing Facility, Intermediate Care-State Owned
460	Dental Program – Adult	110	Nursing Facilities, Skilled Care
450	Dental Program - under 21	140	Nursing Facility, Skilled Care - State Owned
790	Diagnostic Screening and Prevention (Health Depts. Only)	490	Oral Maxillofacial Surgery (Dentists Only)
721	Dialysis Services – Professional	330	Orthotics & Prosthetics / Hearing Services
720	Dialysis Services – Technical	761	Perinatal Targeted Case Mgt
320	Durable Medical Equipment	300	Pharmacies
800	Early Intervention Case Mgmt	410	Physical Therapy - Medicare Only
970	GAPP- Case Management	430	Physician Services
971	GAPP – In-Home Private Duty Nursing	431	Physician's Assistant Services
972	GAPP-Medically Fragile Daycare	550	Podiatry - Medicare Only
371	Emergency Air Ambulance	730	Pregnancy Related Services
370	Emergency Ground Ambulance	570	Psychological Services (Psychologists)
270	Family Planning Services	420	Rehabilitation Therapy – Medicare Only
850	Georgia Better Health Care	540	Rural Health Clinic, Federally Qualified

600 Health Check Services
 200 Home Health Services (Agency)
 690 Hospice
 010 Hospital – Inpatient (Facility)
 070 Hospital – Outpatient (Facility)
 080 Hospital - Swing-bed (Facility)

542 Rural Health Clinic, Free Standing
 541 Rural Health Clinic, Hospital-based
 930 SOURCE
 400 Speech Therapy - Medicare Only
 762 Targeted Case Management for Adults with AIDS
 870 Therapeutic Residential Intervention Svc
 470 Vision Care

4. Group Code valid values:

G Group Owner Only
 M Group Member
 N None

I Individual
 O Group Owner / Member

5. Specialty Codes valid values:

Please see attached list

E. License and Certification Information:

1. License information may be required based on the Category of Service for which you are applying.
2. Were you ever licensed in another state?
3. Certification information may be required based on the Category of Service for which you are applying.
4. Clinical Laboratory Improvement Amendment certification is required if you will bill laboratory procedure codes at this location.
5. Pharmacies are required to provide Drug Enforcement Agency permit information. Physicians who possess DEA permits are also required to provide this information.
6. Pharmacy applicants are required to provide this information. Pharmacy Class Code valid values:

A	Retail Chain Pharmacy	R	Retail Pharmacy
H	Hospital Pharmacy	C	Clinic Pharmacy

F. Exclusion / Sanction Information:

- 1-4. Please provide accurate information regarding previous and current exclusions and sanctions.

G. Correspondence Medium Information:

1. Receiving letters (including rosters, if applicable) by paper is ONLY available to individuals who are not capable of receiving information in an electronic format.
2. Receiving bulletins by paper is ONLY available to individuals who are not capable of receiving information in an electronic format.
3. Receiving remittance advices by paper is ONLY available to individuals who are not capable of receiving information in an electronic format. The x12-835 option requires that you have a contract with a clearinghouse.
4. Submitting point-of-sale claims is ONLY allowed for pharmacy providers.

H. Signatures and Contact Information:

1. Please provide contact information for the person who will be able to answer questions regarding this application.
2. Applications for individual practitioners must be signed by the applicant. Facility applications should be signed by the administrator.

Provider Enrollment Application Instructions – D5
Specialty Codes valid values

001	Acupuncture Medicine	002	Addictionologist	003	Administrative Medicine
004	Adolescent Medicine	005	Adult Day Health Care	006	Aerospace Medicine
008	Allergy	009	Allergy and Immunology	010	Alternative Living Services
011	Ambulance Company, Licensed	012	Ambulance Company, non-license	013	Ambulatory Surgery
014	Anatomic Pathology	015	Anesthesiology	016	Anesthesiology Critical Care M
017	Athletic Trainer, Certified	018	Audiologist	019	Audiology Services
020	Aviation Medicine	021	Behavioral Mgmt Svcs, Pediatri	022	Birthing Center
024	Broncho-Esophogology	025	Cardiac Electrophysiology	027	Cardiology
028	Cardiovascular Disease	029	Cardiovascular Surgery	030	Case Management
031	Cert Registered Nurse Anesthet	033	Child Birth Education	034	Chiropractics Examiner
038	Clinical Pharmacology	039	Colon and Rectal Surgery	040	Community Health Centers
041	Counselor, Professional	042	Critical Care Medicine	043	Cytopathology
044	Day Habilitation	045	Day Treatment Services	046	Dedicated Case Management
047	Dentistry, General Practice	048	Dermatology	049	Dermatopathology
050	Dermatology Immunology / Diag	051	Diabetes	054	Diagnostic Radiology
055	Dialysis, Professional	056	Dialysis, Technical	057	Disproportionate Share Hospita
058	Durable Medical Equipment Supp	059	Ear, Nose, Throat	060	Early Intervention, Agency
061	Early Intervention, Individual	062	Emergency Medicine	063	Emergency Treatment Facility
064	Emergency Response System	065	Endocrinology	066	Endodontics
067	Environmental Modifications	069	Eye, Ear Nose, Throat	071	Family Planning
072	Family Practice	073	Family Practice Geriatric Medi	074	Gastroenterology
075	General Practice	076	General Surgery	077	Geriatrics
078	Geriatric Psychiatry	079	Clinic or other Group Practice	080	Gynecology
081	Hand Surgery	082	Health Check, Health Dept	083	Health Check, Other
084	Hematology	085	Hematology/Oncology	086	Home Delivered Meals
087	Home Delivered Services	088	Home Health Agency	090	Hospice Facility
091	Hospital, Regular General	092	Hospital, Military	093	Hospital, Psychiatric, Freesta
094	Hospital, Specialized Long Ter	095	Hyperbaric Facility, Freestand	097	Immunology
098	Immunopathology	099	Independent Lab	100	Infectious Diseases
102	Internal Medicine	103	Internal Medicine Critical Car	105	Laryngology
107	Licensed Clinical Social Worke	108	Licensed Dietician	111	Maternal and Fetal Medicine
112	Maxillo-Facial Surgery	115	Medical Toxicology	117	Migrant Health
118	Molecular Genetics, Clinical	119	Neonatology	120	Neonat-Perinatal Medicine
121	Neopathology	122	Neoplastic Oncology	123	Nephrology
124	Neurology	125	Neurological Surgery	126	Neuro-Ophthalmology
127	Neuropathology	128	Neuropsychology, Clinical	129	Neurophysiology, Clinical
130	Neuroradiology	133	Nuclear Cardiology	134	Nuclear Medicine
135	Nuclear Radiology	136	Nurse Midwife, Contracted	137	Nurse Midwife, Non-Contracted
138	Nurse Practitioner, Adult	139	Nurse Pract, Family Health	140	Nurse Practitioner, General
141	Nurse Practitioner, Geriatric	142	Nurse Practitioner, OB/GYN	143	Nurse Practitioner, Pediatric
144	Nursing Home / Domiciliary Fac	145	Nutrition	146	Obstetrics
147	Obstetrics & Gynecology	148	Obs & Gynecology Crit Care	149	Occupational Medicine
151	Occupational Therapy	152	Ocularists	153	Oncology
154	Ophthalmology	155	Optometry	156	Oral Maxillofacial Surgery
157	Oral Surgery	159	Orthodontics	160	Orthodontic Prosthetics, Non A
161	Orthopedic Surgery	162	Orthopedic Hand Surgery	163	Orthotists
164	Osteopathy	165	Otolaryngology	166	Otology, Laryngology, Rhinolog
167	Pain Management	168	Pathology	170	Pediatrics
171	Pediatric Allergy	172	Pediatric Cardiology	173	Pediatric Developmental & Beha
175	Pediatric Emergency Medicine	176	Pediatric Endocrinology	177	Pediatric Gastroenterology
178	Pediatric Hematology-Oncology	179	Pediatric Infectious Disease	180	Pediatric Internal Medicine
181	Pediatric Nephrology	182	Pediatric Neurology	183	Pediatric Neurosurgery
184	Pediatric Pathology	185	Pediatric Pulmonology	186	Pediatric Rheumatology
187	Pediatric Sports and Fitness M	188	Pediatric Surgery	189	Pediatric Ophthalmology
190	Pediatric Orthopedics	191	Pediatric Otol, Laryng, Rhin	192	Pediatric Urology
193	Pedodontics	194	Perinatology	195	Periodontics
196	Periph Vascular Disease	197	Personal Support	198	Pharmacy
199	Pharmacy Supplies	200	Physical Medicine Rehab	201	Physical Therapist
203	Physician Assistant	204	Physician Assistant, Anesthesi	205	Plastic Surgery
206	Plastic Surgery Hand Surgery	207	Podiatry	208	Practical Nurse, Licensed
209	Pregnancy Related Services	210	Pregnant Substance Abuse Day T	211	Preventative Medicine
212	Proctology	213	Professional Nurse	214	Prosthetists
215	Prosthodontics	218	Psychiatric Nurse	219	Psychiatric Social Worker
220	Psychiatry, Board Certified	221	Psychiatry, Child/Adol	222	Psychology
223	Public Health	224	Public Health Dentistry	225	Pulmonary Medicine
227	Radiation Oncology	228	Radiation Therapy	229	Radioisopic Pathology
230	Radioisotopic Pathology	232	Radiology	234	Registered Nurse
236	Rehab Services, DSPS	239	Rehabilitation Medicine	240	Renal Dialysis Center
241	Reproductive Endocrinology	242	Residential Modification Servi	243	Respite Care, In Home
244	Respite Care, Out of Home	245	Rheumatology	246	Rural Health
247	School Nurse	248	Skilled Nursing / Extended Car	249	Skilled Nurse Services

251	Speech-Language Pathology	252	Speech Therapy	253	Sports Medicine
254	Internal Sports Medicine	255	Substance Abuse Treatment Faci	256	Surgical Oncology
257	Surgery	258	Surgery, Critical Care	259	Supported Employment
260	Swingbed Hospital	261	Targeted Case Management	262	Therapeutic Radiology
263	Thoracic Surgery	264	Transplant Surgery	265	Transplant Surgery, Liver
266	Traumatic Brain Injury	268	Urology	269	Vascular Surgery
272	Residential Training and Super	273	Medical Supplies	274	Institutional Based
275	Vehicle Adaptation	276	Day Support Services	278	Presumptive Eligibility
279	Pediatric Plastic Surgery	280	Pediatric Dermatology	281	Pediatric Ear, Nose, Throat
282	Pediatric Interventional Radiology	283	Pediatric Medical Toxicology	284	Pediatric Neurodevelopment
285	Pediatric Rehab Medicine	286	Pediatric Radiology	289	Behavioral Management
290	Interventional Radiology	291	Hospice Based Physicians	294	Natural Support Enhancement
295	Natural Support Therapy				

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
PROVIDER ENROLLMENT APPLICATION**

A. Applicant:

1. Individual Practitioners ONLY

First M.I. Last Suffix (Jr, III, etc.) Title (MD, RN, etc)

Name of your practice (if applicable):

2a. Facility/Agency ONLY: (Must be Signed by the Administrator)

Legal Business Name

“Doing Business As” Name

Type of Facility (see instructions for list of valid values.) State Where Incorporated

2b. Does this organization operate other sites, locations or units? No; Yes
Where: _____

3. Office Manager Information:

Name

Email Address

Social Security Number

Date of Birth

POA ID#:(if available) _____

B. Address Information:

1. Office (Physical) Address:

Street Address (P.O. Box Not Acceptable) Suite No.

City County State Zip Code (+ 4)

() Office Telephone Number () Office Fax Number

() After Hours Telephone Number

Office E-mail Address (if available)

Office Website Address (if available)

Is this location open 24 hours? No; Yes Is this location TDD/TTY equipped? No; Yes

2. Mailing Address (if different from physical address):

Street Address /PO Box	Suite No.		
City	County	State	Zip Code + 4
()		()	
Alternate Telephone Number		Alternate Fax Number	
Alternate E-mail Address (if available)		Alternate Website Address (if available)	

3. Pay-to Address: The pay-to address should be placed on the W-9 form.

C. Detailed Information:

1. Individual only:

a. Social Security #: _____ b. Date of Birth: _____

c. Hospital Admitting Privileges (past or current) or alternative arrangement* (Please use an additional sheet if necessary):

Provider Name			
Name of Hospital	City/State	Begin Date	End Date
Alternative arrangement:			

Provider Name			
Name of Hospital	City/State	Begin Date	End Date
Alternative arrangement:			

Provider Name			
Name of Hospital	City/State	Begin Date	End Date
Alternative arrangement:			

***GBHC PCPs must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the GBHC authorization requirements.**

2. Bed Data – How many of your beds are for:

Intermediate Care: _____ Skilled Care: _____ Inpatient: _____ Mental Retardation: _____

3. All applicants:

a. Federal Employer ID#: _____ b. NPI #: _____

c. Existing Georgia Medicaid Payee Provider #: _____

d. Does this applicant have Medicare certification? (Please attach a copy of your Medicare certification award letter.)

Medicare Provider Number	Effective Date
Part A or Part B?	Medicare Carrier/Intermediary Name
Medicare ONLY (For billing Crossover Claims <u>only</u> .) UPIN #: _____	

e. Has the applicant ever participated in another state's Medicaid program? No; Yes If yes, list state(s) and provider number(s). Attach additional sheets if necessary.

Medicaid Number	State	Type of Service(s) Provided	Active	Inactive

f. Languages spoken (Please put a check by the primary language):

g. Special Needs (What special needs are accommodated at this provider location?)(see instructions for valid code values):

h. Liability Insurance amount: _____
(required for certain programs) (attach a copy of proof of insurance)

D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type Code: _____ 2. Practice Type Code: _____

3. Category (ies) of Service: _____ 4. Group Code: _____

5. Specialty Code(s): _____

E. License and Certification Information:

1. License Information for state of practice (Attach a copy):

a. _____
License Number Type Effective Date Expiration Date

b. If the applicant is an individual practitioner:
Do you have public board orders? No; Yes If yes, date of the last order?: _____

Are you: Board Eligible; Board Certified Specialty: _____

2. License/Certification information from other states (attach additional sheets if necessary):

State	License Number	Type	Effective Date	Expiration Date
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3. Certification Information (Attach a copy):

Type	Certification Number	Effective Date	Expiration Date

Type	Certification Number	Effective Date	Expiration Date

4. CLIA Certification Information (attach copy of certificate for this location):

Number	Certification Type	Effective Date	Expiration Date

CLIA FEIN	CLIA SSN

5. DEA Permit Number: _____
All schedules? No; Yes; Not applicable

6. Pharmacies Only:
Drug Store Type: Proprietary; Non-Proprietary Pharmacy Class Code: _____
National Council for Prescription Drug Programs (NCPDP) Number: _____

F. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
No; Yes (If "yes", please attach details)
2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
No; Yes (If "yes", please attach details)

Has any member of your practice had a recoupment of over \$5,000 in any 18 month period?
No; Yes (If "yes", please attach details)
3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
No; Yes

If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

First	M.I.	Last	Title (if applicable)	Relationship

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
No; Yes (If "yes", please attach detailed explanation and disposition of case)

G. Correspondence Medium Information:

This section of the application provides you with the opportunity to select your preferred method for receiving various forms of information from the Department. Selecting a choice is optional. If no choice is provided, your file will be defaulted to the standard options; but may be changed at any time. You are not guaranteed or restricted by your choice. Please note: In most cases, “paper” is ONLY available to individuals who are not capable of receiving information in an electronic format.

1. Letter Medium: *Please select your preferred method for receiving letters from the Department:*

Email Fax Paper Web Portal message center

2. Bulletin Medium: *Please select your preferred method for receiving notices and other bulletins from the Department:*

Paper Web Portal message center

3. Remit Medium: *Please select your preferred method for receiving remittance advices from the Department:*

Paper Web Portal message center
X-12-835 via Clearinghouse

4. Billing Medium: *Please select your preferred method for submitting claims to the Department: (NOTE – WINASAP requires special software, which is available through the ACS Billing Office. For more information, call 1-800-987-6715)*

Point of Sale Batch Web Portal claims submission area Paper
WINASAP*/Dial-up

H. Signatures and Contact Information:

1. Contact Person Information

List the contact person in your office who may answer questions regarding this application:

Contact Person

Title

Mailing Address (if different from enrolling address)

Telephone Number

Fax Number

E-Mail Address (if available)

2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Category(ies) of Service indicated herein.

Printed Name of Applicant

Signature of Applicant

Date

**DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE**

STATEMENT OF PARTICIPATION

THIS STATEMENT OF PARTICIPATION between the State of Georgia, Department of Community Health, Division of Medical Assistance (the "Department") and the undersigned Provider becomes effective on the date of enrollment indicated by the Department.

WHEREAS, the Department is charged with the administration of the Georgia State Plan for Medical Assistance (the "Medicaid program") in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. § 49-4-1 *et seq.*, and seeks to enroll qualified health care providers ("Providers") to render services to eligible Medicaid recipients;

WHEREAS, Provider affirms that all prerequisites, certification and/or licensure requirements and other necessary qualifications have been met in Provider's area(s) of specialty as required by law in the State of Georgia to render health care services to patients; and,

WHEREAS, Provider desires to enroll in the Medicaid program to render Covered Services to eligible Medicaid recipients under certain category(ies) of service, and seeks reimbursement for rendering such services.

NOW THEREFORE, in consideration of the mutual covenants and promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the terms and conditions named herein as follows:

1. THE DEPARTMENT'S OBLIGATIONS

- A. Legal Compliance. The Department shall adhere to all applicable provisions of federal and state laws and regulations, Rules of the Department, and all of the Department's Policies and Procedures manuals governing the Medicaid program, and any amendments thereto (collectively, the "Department's requirements").
- B. Reimbursement to Providers. The Department shall reimburse Provider for claims that are submitted in compliance with the Department's requirements, and in such amounts allowed under the Medicaid program as administered by the Department.
- C. Modifications to Department's Policies and Procedures. The Department shall notify Provider of modifications to the provisions contained in the Policies and Procedures manual(s) for the category(ies) of service in which the Provider is enrolled by disseminating such notices to the address(es) at which Provider is then registered with the Department. Public notice of significant changes in the Department's methods and standards for setting payment rates for Covered Services will be given in accordance with the Rules governing the Department.

2. PROVIDER'S OBLIGATIONS

- A. Legal Compliance. Provider shall comply with all of the Department's requirements applicable to the category(ies) of service in which Provider participates under this Statement of Participation, including Part I, Part II and the applicable Part III manuals. The term "Provider" shall include those persons or entities performing services under the supervision or other direction of Provider, and all acts or omissions of such persons or entities shall be attributed to Provider.
- B. Provider Enrollment and Continued Participation. Provider shall comply with the Department's requirements to enroll and continue participating as a Provider in the Medicaid program, including but not limited to completion of all enrollment forms, cooperation with site audits, and the following:

1. Certification of Provider Information. Provider certifies that all statements and information furnished to the Department for enrollment and continued participation are true and complete, and recognizes that the Department will rely on such information to evaluate Provider's participation under the Medicaid program. Provider shall give the Department written updates to information previously submitted, and advance notice of changes when required by the Department in this Statement of Participation and the Department's requirements.
2. Disclosure.
 - a. Business Transactions. Within thirty-five (35) days of a request, Provider shall submit to the U.S. Department of Health and Human Services or the Department full and complete information about (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request; and (b) any significant business transactions between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request. Failure to disclose information as requested will result in denial of reimbursement from the date after which the information is due until the day before it is supplied.
 - b. General Disclosure. Provider authorizes the Department to request, copy, access, use and share Provider's records and other information as may be necessary for the Department to determine the appropriateness of Provider's participation in or termination from the Medicaid program, subject to any applicable state or federal laws which may deem such records or parts of such records privileged or confidential. Provider's records and information may be requested from or exchanged with any source, including but not limited to the Composite State Board of Medical Examiners, any federal or state governmental agency, accreditation agency, licensing agency, regulatory body, certifying agency, or any other person or entity, subject to any applicable state or federal law limiting the distribution of such information. Provider's authorization to request, copy, access, use and share records and other information includes but is not limited to disclosure of ownership or control interests, and of any criminal offenses related to any federal or state health care program. This disclosure provision shall exclude sanctions against Provider that are protected by private order of the issuing board or agency.
3. License/Certification. Provider shall possess and maintain in good standing and without restriction valid professional, occupational, facility or other license and/or certification that is necessary for rendering Covered Services in the selected category(ies) of service, and as required by the Department. Provider shall provide the Department with written copies of licenses and/or certifications upon request. Except where disclosure is protected by private order of the issuing board or agency, Provider shall inform the Department promptly in writing of any restriction or adverse action against Provider's license and/or certification.
4. Hold Harmless. Provider releases from liability and holds harmless the Department, its agents, and any and all individuals and entities who, in good faith, furnish or release information for any acts performed and statements made or released in connection with the evaluation of Provider under the Medicaid program including the services rendered by Provider, and other matters pertinent to Provider's status and duties in connection with this Statement of Participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.
 - A. Claims Submission; Certification of Claims. Provider shall submit claims for Covered Services rendered to eligible Medicaid recipients in the form and format designated by the Department. For each claim submitted by or on behalf of Provider, Provider shall certify each claim for truth, accuracy and completeness, and shall be responsible for research and correction of all billing discrepancies without cost to the Department. This provision shall survive termination or expiration of this Statement of Participation for any reason.
 - B. Recipient Records. Provider shall maintain in an orderly manner and ensure the confidentiality of all original source documents, medical records, identifying recipient data, and any copies thereof, as may be necessary to fully substantiate the nature and extent of all

services provided. Records shall be retained for a minimum of five (5) years from the date of service, or longer as required by state or federal law. Upon request by the Department, its agent, and any authorized agency including but not limited to the U.S. Department of Health and Human Services, the Comptroller General, the State Auditor, State Attorney General's Office or office of any Georgia District Attorney and their authorized representatives, Provider shall disclose and provide legible copies to the requestor, or permit the requestor to copy, without cost, all Medicaid-related documents, records or data. This provision shall apply to all records regardless of the enrollment status of Provider, subject to any applicable state or federal laws that may deem such records or parts of such records privileged or confidential. Provider's failure to abide by this provision may constitute grounds for disallowance of all applicable charges, recoupment of corresponding payments, and/or termination of Provider's participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.

- C. Covered Services. Provider shall render Covered Services, as defined in the Department's Policies and Procedures manuals, to eligible Medicaid recipients that are medically necessary as defined by the Department, within the parameters permitted by Provider's license or certification, and within the category(ies) of service indicated in the Provider Enrollment documents. By submitting claims for reimbursement, Provider certifies that Covered Services were rendered in the amount, duration, scope and frequency indicated on the claims. Provider shall not discriminate against any recipient on the basis of race, color, national origin, religion, sex, marital status, age, disability, health status, or source of payment.
- D. Reimbursement for Covered Services. Reimbursement for Covered Services performed shall be made in a form and format designated by the Department. Payment shall be made in conformity with the provisions of the Medicaid program, applicable federal and state laws, rules and regulations promulgated by the U.S. Department of Health and Human Services and the State of Georgia, and the Department's Policies and Procedures manuals in effect on the date the service was rendered. Such reimbursement shall constitute payment in full for Covered Services rendered, and Provider shall not bill, accept or seek payment from eligible Medicaid recipients, except for applicable co-payments, co-insurance or deductibles required by the Department. Without cost to the Department or its agents, Provider agrees to cooperate with refund and recoupment efforts to the Department, and shall assist in recovering any amounts for which a third party may be liable. Provider agrees that the Department shall not reimburse any claim, or portion thereof, for services rendered prior to the effective date of enrollment indicated by the Department or for which federal financial participation is not available.

Provider acknowledges that payment of claims submitted by or on behalf of Provider will be from federal and state funds, and the Department may withhold, recoup or recover payments as a result of Provider's failure to abide by the Department's requirements. This provision shall survive termination or expiration of this Statement of Participation for any reason.

- E. Prohibition on Reassignment. Provider acknowledges and agrees that the payee or billing service designated by Provider to receive payments or to process claims is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Furthermore, payment to the payee or billing service for services rendered shall be related to the cost of processing, and shall not be based on the payments due to Provider or based upon the percentage of claims processed.
- F. Indemnification. Provider shall indemnify and hold harmless the Department and its agents from all causes of action, claims, suits, judgments, or damages, including court costs and attorneys' fees, arising out of the misconduct, negligence or omissions of Provider in the course of participating in the Medicaid program, including but not limited to the provision of services to an eligible Medicaid recipient or a person believed to be a recipient. If and to the extent such damage or loss (including costs and expenses) is covered by any funds established and maintained by the State of Georgia, Provider agrees to reimburse the funds for such monies paid out by such funds. This provision shall survive termination or expiration of this

Statement of Participation for any reason.

3. TERM; TERMINATION

- A. Term. Unless otherwise renewed and subject to the Department's requirements for continued participation, this Statement of Participation shall expire automatically at 11:59 p.m. on June 30 of each year. The Department, in its sole discretion, has the option to renew this Agreement for an additional fiscal year, and if exercised, the Department shall issue written notice to Provider prior to the end of the then-current fiscal year. The Department has the right to terminate this Agreement at any time with or without cause under applicable laws, rules or regulations.
- B. Termination by Provider. Unless otherwise authorized by the Department or by law, Provider shall give ten (10) days prior written notice to the Department of voluntary termination.
- C. Termination under Other Programs. The Department may terminate and take other action against Provider under the Medicaid program when adverse action is taken against Provider under any other plan or program, including but not limited to exclusions from or licensure restrictions or conditions by other federal or state authorities, plans or programs. The Department shall issue written notice of termination to Provider to be effective on the date indicated therein. The Department also may notify other state and federal authorities, plans or programs of Provider's enrollment status in the Medicaid program, including other plans or programs within the Department. Termination under the Medicaid program may result in Provider's termination under other federal and state plans or programs.
- D. Termination for Unavailability of Funds. Notwithstanding any other provision hereof, in the event that funds are no longer appropriated for the Department, Division of Medical Assistance by the General Assembly of the State of Georgia or from the Congress of the United States of America, or in the event that the sum of all obligations of the Department incurred pursuant to the Medicaid program equals or exceeds the balance of such sources available to the Department for "Medical Assistance Benefits" for the fiscal year in which this Statement of Participation is effective less one hundred dollars (\$100.00), then this Statement of Participation shall terminate immediately without further obligation to or by the Department. The certification by the Commissioner of the Department of the occurrence of either of the events stated above shall be conclusive. The Department will attempt to provide Provider with ten (10) days notice of the possible occurrence of events described in this provision.

4. GENERAL PROVISIONS

- A. Notice. All mailed notices shall be issued to the Provider's address on record with the Department as of the date of such notice.
- B. Waiver of Breach. Waiver of breach of any provision of this Statement of Participation shall not be deemed a waiver of any other breach of the same or different provision of this Statement of Participation.
- C. Conflict of Interest. The parties certify that the provisions of O.C.G.A. § 45-10-20 *et seq.*, as amended, and 41 U.S.C. § 423 regarding conflicts of interest have not and will not be violated in any respect.
- D. Headings. The headings of sections and provisions contained herein are for reference purposes only and shall not affect in any way the meaning or interpretation of this Statement of Participation.
- E. Governing Law. This Statement of Participation shall be governed by and construed in accordance with the laws of the State of Georgia.
- F. Assignment. Provider may not assign any right or obligation under this Agreement without the prior written consent of the Department.
- G. Amendments. Except as otherwise specifically provided herein, amendments or modifications to

this Statement of Participation shall be in writing and signed by each party.

- H. Provider-Patient Relationship. Nothing in this Statement of Participation shall be construed to interfere with or in any way alter any Provider-patient relationship or interfere with the obligations of Provider to exercise independent medical judgment in rendering health care services to patients or in governing the level of care of a patient.
- I. Independent Relationship. This Statement of Participation establishes the means and terms of reimbursement between the Department and Provider, but does not prescribe the conduct of any medical or other professional practice. No provision in this Statement of Participation is intended to create or shall be deemed or construed to create any relationship between the Department and Provider other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Statement of Participation. Neither the Department nor Provider is or shall be considered an employer, employee, agent, partner or joint venture of the other.
- J. Binding Authority. Each party acknowledges that it has the full power and authority to enter into and perform this Statement of Participation and the person signing on behalf of each party has been properly authorized and empowered to enter into this Statement of Participation.
- K. Entire Agreement. This Statement of Participation, together with the Department's Policies and Procedures manuals, all enrollment documents, and any amendments thereto, shall constitute the entire agreement between the parties with respect to the subject matter contained herein, and shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties.

IN WITNESS WHEREOF, Provider executes this Statement of Participation in person, or as an authorized party on behalf of an entity, to become effective on the date indicated by the Department.

Accepted and authorized on this _____ day of _____, in the year _____

(**“Provider”**)

(Printed Name of Enrolling Provider)

Provider's Signature: _____

(Printed name and title of Authorized Agent (for non-individual practitioners only))

Authorized Agent's Signature: _____

**DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE (the “Department”)**

Accepted and authorized on this _____ day of _____, in the year _____

BY: _____
DIRECTOR, DIVISION OF MEDICAL ASSISTANCE

INTERNAL REVENUE SERVICE FORM W-9
REQUEST FOR TAXPAYER
IDENTIFICATION NUMBER AND CERTIFICATION

The Internal Revenue Service (IRS) Form W-9 provides information pertaining to your Taxpayer Identification Number (TIN) and Payee name. All Payee information is captured from the W-9. The Department uses this information to issue payments and report provider year-end earnings to the IRS.

THE INFORMATION ON THE W-9 MUST MATCH THE INFORMATION REGISTERED WITH THE IRS.

If you have multiple locations and use a different TIN for the other locations, you must submit a separate W-9 for each TIN.

Note: If the Payee listed on the W-9 is different from the applicant, please complete and submit the Power of Attorney for Payee.

The Department reserves the right to request confirmation of the Taxpayer Identification Number. Acceptable forms of confirmation are a copy of the applicant's Social Security card, Federal Tax Deposit Coupon (Form 8109), or other correspondence from the IRS.

Submit all materials to:

GHP Provider Enrollment
Post Office Box 4000
McRae, Georgia 31055-4000

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	
City, state, and ZIP code		
Requester's name and address (optional)		
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number
+

or

Employer identification number
+

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **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. person (including a U.S. resident alien).

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. (See the instructions on page 4.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% after December 31, 2003; 28% after December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9**.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Exempt payees. Backup withholding is **not required** on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);
2. The United States or any of its agencies or instrumentalities;
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or
5. An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

6. A corporation;
7. A foreign central bank of issue;
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Additional Location Application Form**

A. Applicant:

1. Current Rendering Provider Number(s): _____

2. Payee Provider Number (if known): _____

First	M.I.	Last	Suffix (Jr, III, etc.)	Title (MD, RN, etc)
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Social Security #: _____ Practitioner's D.O.B.: _____

Practice or Business Name (if applicable):

3. Pharmacies ONLY:

Legal Business Name

"Doing Business As" Name

Does this organization operate other sites, locations or units? No; Yes Where: _____

c. Drug Store Type: Proprietary; Non-Proprietary d. Pharmacy Class Code: _____

4. Office Manager's Information:

Name

Email Address

Social Security Number

Date of Birth

B. Address Information:

1. Office (Physical) Address:

Street Address **(P.O. Box Not Acceptable)** Suite No.

City	County	State	Zip Code (+ 4)
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(____) _____ (____) _____
Office Telephone Number Office Fax Number

(____) _____
After Hours Telephone Number

Office E-mail Address (if available)

Office Website Address (if available)

Is this location open 24 hours? No; Yes Is this location TDD/TTY equipped? No; Yes

2. Mailing Address (if different from physical address):

Street Address /PO Box _____ Suite No. _____

City _____ County _____ State _____ Zip Code + 4 _____

(_____) _____ (_____) _____
Alternate Telephone Number _____ Alternate Fax Number _____

Alternate E-mail Address (if available) _____ Alternate Website Address (if available) _____

3. Pay-to Address: The pay-to address should be placed on the W-9 form.

C. Detailed Information:

1. Federal Employer ID#: _____ 2. UPIN#: _____

3. Does this applicant have Medicare certification? *(Please attach a copy of your Medicare certification award letter.)*

Medicare Provider Number _____ Effective Date _____

Medicare Carrier/Intermediary Name _____

Medicare ONLY *(Check this box if you intend to bill Crossovers only.)*

4. Languages spoken at this location (Please put a check by the primary language)*(see instructions for valid code values):*

_____ _____ _____ _____

5. Special Needs (What special needs are accommodated at this provider location?)*(see instructions for valid code values):*

6. Liability Insurance amount: _____
(required for certain programs) (attach a copy of proof of insurance)

D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type Code: _____ 2. Practice Type Code: _____

3. Category(ies) of Service: _____ 4. Group Code: _____

5. Specialty Code(s): _____

E. License and Certification Information:

1. License Information for state of practice (Attach a copy):

a. _____
License Number _____ Type _____ Effective Date _____ Expiration Date _____

b. Do you have public board orders? No; Yes If yes, date of the last order: _____

Are you: Board Eligible; Board Certified Specialty: _____

2. Certification Information (Attach a copy):

Type	Certification Number	Effective Date	Expiration Date
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F. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
No; Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
No; Yes (If "yes", please attach details)

Has any member of your practice had a recoupment of over \$5,000 in any 18 month period?
No; Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
No; Yes

If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

First	M.I.	Last	Title (if applicable)	Relationship
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4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
No; Yes (If "yes", please attach detailed explanation and disposition of case)

G. Signatures and Contact Information:

1. Contact Person Information

List the contact person in your office who may answer questions regarding this application:

Contact Person	Title
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Mailing Address (if different from enrolling address)

Telephone Number	Fax Number	E-Mail Address (if available)
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2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Category(ies) of Service indicated herein.

Printed Name of Applicant

Signature of Applicant

Date

**GA DEPT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Physician's Assistant Application Instructions**

Complete this form only if you are enrolling a physician's assistant (PA) or a physician's assistant anesthesiologist assistant (PAAA) with a sponsoring physician who is already enrolled in Georgia Medicaid. All information pertains to the physician's assistant, unless otherwise indicated.

A. Applicant: Enter the National Provider Identification Number

1. Enter the name, Social Security # and date of birth of the PA / PAAA.
2. Enter the name and Georgia Medicaid provider number of the sponsoring physician.

B. Address Information:

1. Enter the physical address, phone and fax numbers of this location. **A post office box is unacceptable.**
2. Enter the mailing address (if different from the physical address).
3. The Pay-to address should be listed on the IRS form W-9. Enter the established Payee Provider number for this practice and the Federal Employee Identification number.

C. Program Enrollment Information:

The provider type and COS are defaulted for PA/PAAA providers. Please indicate the appropriate provider specialty. Valid values are 203-Physician Assistant or 204-Physician Assistant, Anesthesiology.

Health Check – Attach a copy of the Vaccines for Children approval notice.

D. License and Certification Information:

Enter the PA/PAAA's license information issued by the state in which this practice is located.

E. Exclusion / Sanction Information:

Respond to the questions as requested and attach any additional documentation.

F. Signatures and Contact Information:

1. Enter the name and contact information of the person in your office the Department may contact if there are any questions regarding this application.
2. The applicant and the sponsoring physician must sign the application.

Please attach the following documentation:

1. **A copy of the PA/PAAA's license**
2. **Approval notice from the Composite State Board of Medical Examiners**
3. **Power of Attorney for Payee (completed by the physician's assistant)**
4. **Statement of Participation**
5. **Internal Revenue Service form W-9***
6. **EFT Agreement***

NOTE: * *These forms are not necessary when valid payee provider # is entered in section A.*

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Physician's Assistant Application Form**

A. Applicant: _____ NPI: _____

1. _____
Name: First _____ M.I. _____ Last _____ Suffix (Jr, III, etc.) _____

Social Security #: _____ Practitioner's D.O.B.: _____

2. Sponsoring Physician: _____
Sponsoring Physician's Georgia Medicaid Provider _____

Name: First _____ M.I. _____ Last _____ Suffix (Jr, III, etc.) _____

B. Address Information:

1. Office (Physical) Address:

Name of practice

Street Address (P.O. Box Not Acceptable) _____ Suite No. _____

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

(_____) _____ (_____) _____
Office Telephone Number _____ Office Fax Number _____

(_____) _____
After Hours Telephone Number _____

Office E-mail Address (if available) _____ Office Website Address (if available) _____

2. Mailing Address (if different from physical address):

Street Address /PO Box _____ Suite No. _____

City _____ County _____ State _____ Zip Code + 4 _____

(_____) _____ (_____) _____
Alternate Telephone Number _____ Alternate Fax Number _____

Alternate E-mail Address (if available) _____ Alternate Website Address (if available) _____

3. Pay-to Address: The pay-to address should be placed on the W-9 form.

Georgia Medicaid Payee Provider Number

Federal Employer Identification Number (Attach W-9)

C. Program Enrollment Information:

Provider Type Code: **360** Category of Service: **431** Specialty Code(s): PA (203) or PAAA (204)
 Health Check – Category of Service: 600 (attach VFC approval notice)

Does this applicant participate in the Medicare program? (Please attach a copy of your Medicare certification award letter.)

D. License and Certification Information:**1. License Information for state of practice (Attach a copy):**

- a. _____
 License Number Type Effective Date Expiration Date
- b. Do you have public board orders? No; Yes If yes, date of the last order: _____

E. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
 No; Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
 No; Yes (If "yes", please attach details)

Has any member of your practice had a recoupment of over \$5,000 in any 18 month period?
 No; Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
 No; Yes

If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

First	M.I.	Last	Title (if applicable)	Relationship
-------	------	------	-----------------------	--------------

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
 No; Yes (If "yes", please attach detailed explanation and disposition of case)

F. Signatures and Contact Information:**1. Contact Person Information**

Contact Person	Title
----------------	-------

Mailing Address (if different from enrolling address)

Telephone Number	Fax Number	E-Mail Address (if available)
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2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I and II for the Category of Service indicated herein.

Signature of Physician's Assistant	Date
------------------------------------	------

Signature of Sponsoring Physician	Date
-----------------------------------	------

POWER OF ATTORNEY FOR PAYEE

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, _____ hereby appoints
(Print Provider's Name)

_____, _____,
(Print Payee's Name) (Taxpayer Identification Number)

as attorney-in-fact for the benefit of Provider and in Provider's name, place, and stead for the following purpose:

To receive, as Payee, any reimbursement from the Department of Community Health, Division of Medical Assistance to which Provider may be entitled as an enrolled provider.

Provider agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

Printed Name of Provider

By:

Signature of Provider or Facility Administrator

Title of Authorized Representative

Sworn to and subscribed before me
this _____ day of _____,
in the year _____.

(Notary Public)

My Commission expires: _____

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
ELECTRONIC FUNDS TRANSFER AGREEMENT**

Providers who receive payment of claims under the Title XIX (Medicaid) program in Georgia must agree to the following terms and conditions:

1. Legal Compliance. Provider shall abide by all federal and state laws governing the Medicaid program.
2. EFT Information. Provider will submit EFT information on form DMA-406 that includes the Payee, name of the bank, transit number, account number and a bank letter or voided check on the account to which funds will be transferred.
2. Non-Provider Payee. If the Payee indicated on the EFT Information form DMA-406 is different from the enrolled Provider, Provider must submit to the Department an original signed and notarized Power of Attorney for Payee, DMA-253G. Designation of a payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.
3. Acceptance of Funds. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the Medicaid program within the meaning of the Official Code of Georgia Annotated, Section 49-4-146.1(b)(2). Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment 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.
4. Notice of Changes. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).
5. Alternate Payment Methods. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the address for payments on record with the Department.
6. Incorporated Document. This EFT Agreement is incorporated into the Statement of Participation and shall not modify or eliminate any provision of the Statement of Participation (including applicable Policies and Procedures manuals of the Department) except as specifically provided herein.
7. Expiration or Termination of EFT. Violation of these terms may cause termination by the Department of EFT and/or the Statement of Participation. Expiration or termination of the Statement of Participation for any reason will terminate EFT automatically. The Department will give written notice of termination to Provider.

Payee Provider's Name: _____

Payee Provider's Georgia Medicaid Number: _____

Bank Routing and Transit Number (9 digits): _____

Bank Account Number: _____

Signature of Provider or Authorized Representative of the Provider

Date

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE
Additional Location Addendum for Individual Practitioner
(To be submitted with form DMA-001)**

A. Applicant:

1. Name: _____

Office Administrator's ID#: _____ (if available)

B. Address Information:

1. Office (Physical) Address:

Street Address **(P.O. Box Not Acceptable)** _____ Suite No. _____

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

(____) _____ (____) _____
Office Telephone Number Office Fax Number

(____) _____
After Hours Telephone Number

Office E-mail Address (if available) _____ Office Website Address (if available) _____

Is this location open 24 hours? No Yes Is this location TDD/TTY equipped? No Yes

FOR DEPARMENTAL USE ONLY

Enterprise I.D. #: _____

Location Alpha: _____

Payee#: _____