

Requirements For Provider Type 01 – Drug and Alcohol Rehabilitation

Specialty Types

Please choose your Specialty and Code.

019- Inpatient Drug and Alcohol Hospital

441- Drug and Alcohol Rehabilitation Unit

Provider Eligibility Program (PEPs)

Please choose the appropriate PEP(s) from the following:

- Fee-For-Service
- Non- Waiver Mental Retardation Base Programs
- Pennsylvania Department of Aging Waiver (PDA) and Bridge Program

Send your required documents to:

DHS Provider Enrollment

PO Box 8045

Harrisburg, PA 17105-8045

- or -

Fax: (717) 265-8284

- or -

Email: RA-ProvApp@pa.gov

**DOCUMENTS REQUIRED FOR THE ENROLLMENT OF
INPATIENT DRUG AND ALCOHOL UNIT AND INPATIENT DRUG AND ALCOHOL REHABILITATION
HOSPITAL**

DOCUMENT REQUIRED	PROVIDER TYPE TO BE ENROLLED	
	Inpatient D&A Unit	Inpatient D&A Rehabilitation Hospital
A copy of an acceptable utilization review plan, written according to the requirements in State Regulations § 1163.473 and Federal Regulations at 42 CFR 456.100. The utilization review plan must be signed by an executive officer.	X	X
A copy of your transfer agreement with a skilled nursing facility, a psychiatric facility, a private psychiatric hospital, and/or an acute care hospital	X	X
A signed copy of the Office of Medical Assistance Programs' Required Provider Agreement for Inpatient Hospitals and Residential Treatment Facilities. Must be signed by an executive officer.	X	X
One signed copy of the Office of Medical Assistance Programs' Provider Enrollment Base Application.	X	X
A copy of the license issued by the Office of Drug and Alcohol Programs.	X	X
A copy of your certification from the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or Det Norske Veritas Healthcare, Inc.	X	X
A copy of the Ownership/Control Interest Form		X
A copy of projected cost report (MA 336).	X	X
A copy of the documentation certifying that at least 75% of the patient population required treatment for drug and alcohol abuse during the most recent 12-month reporting period.		X
A copy of the documentation confirming the number of beds in your drug and alcohol unit as of the date of your enrollment.	X	
A copy of your Medicare certification.	X	X
A copy of the Provider Participation Approval Letter from the Bureau of Fee-for-Service Programs or Letter of Nonreviewability	X	X
A copy of your most recent Home state Medicaid rate letter for your rehabilitation hospital.	Out-of-State	Out-of-State

Contact Person: _____

Title: _____

Telephone Number: _____