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

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Note: This application is for facilities/agencies wishing to enroll only in the Children's Health Insurance Program (CHIP). Facilities/Agencies seeking enrollment in Pennsylvania's Medical Assistance Program in addition to CHIP should submit the appropriate application for their Provider Type to enroll in Medical Assistance. For further information, please visit

http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Instructions

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

2. Check the appropriate box for the action(s) requested
   a. Initial Enrollment - This address is not actively enrolled on the facility/agency file and needs added/reactivated
   b. Revalidation - This address is currently active on the facility/agency file and needs updated per ACA regulations
   c. For those facilities/agencies that have enrolled previously, indicate the facility/agency's MA ID number (if known).

3. Enter the assigned National Provider Identifier (NPI) Number and taxonomy code(s)
   - Valid DHS taxonomies are listed in the "Provider Type/Provider Specialty to Taxonomy Crosswalk" at http://www.dhs.pa.gov/provider/nationalprovideridentifiernpiinformation/index.htm
   - Attach an additional sheet if there are more than four (4) taxonomies for this location

4. Enter the requested effective date for the action request

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

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

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

8. Fictitious names:
   a. Check the appropriate box to indicate whether or not the business operates under a fictitious name.
   b. Enter the D/B/A name and permit number.

9. Check the appropriate box for the business type of the entity applying for enrollment
   a. Include a legible copy of the corporation papers or business partnership agreement (if applicable)
   b. **If Not-for-Profit, include proof of tax exemption (if applicable)**

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

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

12. Enter the physical address of the service location
    a. The address must be a physical location - **NOT** a post office box - **Please note: All addresses will be geocoded per the US Postal Service (**https://tools.usps.com/go/ZipLookupAction!input.action**)**
    b. The phone/fax numbers must be for the service location
    c. Check the appropriate boxes to denote if this location has been enrolled, credentialed and/or revalidated by one of the listed entities within the last 5 years.
    d. Check the appropriate boxes to denote if this address should also be used as the Home Office or Mail To.

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

14. The Provider Eligibility Program (PEP) item has been pre-filled with the appropriate PEP for CHIP-only providers.

15. Check the appropriate box indicating the presence (YES) or absence (NO) of a CLIA certificate and Dept. of Health Laboratory Permit associated with this service location. **If YES, please attach copies of both documents to this application. NOTE: CLIA and DOH Laboratory Permit are only required for Provider Type 28 (Laboratory).**

16. Confidential Information Questions
    a. The representative of the facility/agency applying for enrollment must complete ALL confidential Information questions (A-E)
    b. If answering "Yes" to any of the questions, provide a detailed explanation on a separate piece of paper and attach it to the application. Refer to the confidential information sheet for the information that must be included in the explanation.

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

18. Enter Mail-To/Home Office Information
    a. This page may be used to add a Mail-To and/or Home Office address to the previously listed service location address listed in Question 12.

19. Complete and sign the Provider Agreement

20. Ownership & Control Interest
    a. Section I - This section must be completed by all facilities/agencies
    b. Section II - This section should be completed by any entity that is formed as a corporation, partnership, estate trust or government entity (regardless of for-profit/non-profit status)
    c. Section III - This section should ONLY be completed by non-profit entities that are not formed as a corporation

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

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program identifies a program for which a facility/agency may apply. A facility/agency must be approved in that program to provide services to beneficiaries of that program. Facilities/agencies should use the following PEP when enrolling in CHIP.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Office of CHIP – (800) 986-5437

This program was created to provide quality health insurance to uninsured children that reside in households with income exceeding the current levels for medical assistance. CHIP is comprised of three components. Depending on a family's Modified Adjusted Gross Income and household size, a child can be enrolled in Free, Low or Full Cost CHIP.

Eligibility:

- Be under 19 years of age
- Be a U.S. citizen or qualified alien
- Be a Pennsylvania resident
- Be uninsured or not eligible for MA

Services:

- Immunizations
- Routine check-ups
- Prescription drugs
- Dental care
- Oral surgery
- Vision and eye care
- Hearing Care
- Maternity care
- Inpatient and outpatient mental health services
- Inpatient hospitalization
- Durable medical equipment
- Inpatient and outpatient Substance use disorder treatment
- Partial hospitalization for mental health services
- Rehabilitation therapies
- Home health care
- Hospice and Palliative services
- Medically necessary orthodontia
- Autism spectrum disorder and related services
- Primary and preventive care
- Specialist care
- Case management services
- Chiropractic care
- Diagnostic services
- Emergency care
- Transplant services
- Orthotics and prostheses
- Outpatient habilitation services
- Skilled nursing services
- Surgical services
- Urgent care
- Women's health services
- Telehealth visits
- Participation in qualifying clinical trials
- Pharmacy services
- Gender transition
- Diabetic care

Two PEPs are associated with CHIP services:

- **CHPPR** – used for Individuals and Agencies directly providing healthcare services under CHIP

CHIP PROMISe™ FACILITY/AGENCY ENROLLMENT APPLICATION

1. Enter Name of Facility/Agency:
____

2. Action Request: Check Boxes that Apply:

   a. ☐ Initial Enrollment

   b. ☐ Revalidation

   c. ☐ Check here if previously enrolled in Medical Assistance (MA)
   Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

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

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

4. Requested Effective Date (yyyy / mm / dd):

_____________ / ______ / ______

5. Provider Type Number and Description:

Number: __________

Description: _____________________________________

6. Provider Specialty/Sub-Specialty:

Specialty: ___ ___ ___ Description: _______________________ Sub-Specialty: ___ ___ ___

Specialty: ___ ___ ___ Description: _______________________ Sub-Specialty: ___ ___ ___

7a. Federal Tax ID Number:

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

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

7b. Legal Name Shown on IRS Document:

____

8a. Does the facility/agency operate under a fictitious name?

☐ Yes ☐ No

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

8b. If yes, list the Statement/Permit number and the name.

Number: ___________________________________

Name: _____________________________________

9. Business Type: (Check **one** Box Only)

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

10. a. License Number: _____________________ b. Issuing State: _______________________

c. Issue Date: ___________________________ d. Expiration Date: _____________________

A copy of the facility/agency's license is required for the application to be processed.

11. a. Drug Enforcement Agency (DEA) Number:

____

b. Initial Issue Date: ____________________________ Expiration Date: ___________________________

c. Check this box if you do not have a DEA certificate number: ☐

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

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12. Service Location Address:

NOTE: A <u>Service Location</u> is defined as a physical street address where one or more practitioners:
1.) Maintain an office, 2.) Hold office hours/set appointments and 3.) Render services.

A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.

Each Service Location must be enrolled separately. Additional Service Locations may be submitted with this application using Attachment 1.

Street: ____ Room/Suite:_____________________

City: ______________________ State: ____ Zip: __ __ __ __ __ - __ __ __ __ (9 digits) County: _____________

Business Phone: ( ) _______ - ____________ Fax Number: ( ) ________ - ____________

a. **Has the facility/agency named in Block 1 been screened for this location within the last 5 years by:**

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

____________________	____________________	____________________
Screening State	Screening Contact Phone Number	Screening Contact Email Address

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

If Mail-to and/or Home Office are different from above address, refer to question 18.

13a. Contact Name: ____________________________ Title: ______________________________

***This is the contact name and phone number we will use if we have any questions about this application**

13b. Contact Toll-Free Phone:	13c. Contact Fax Number:	13d. Contact E-mail Address:
( )	( )	

14. Provider Eligibility Program (PEP): Refer to PEP descriptions included in the instructions. **Choose at least 1 PEP.**

a. CHPPR

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15. Are a CLIA certificate and a Dept. of Health Lab License associated with this Service Location?

NOTE: CLIA and DOH Laboratory Permit are only <u>required</u> for Provider Type 28 (Laboratory).

☐ Yes ☐ No **If YES, please provide a copy of both with this application.**

16. Has any agent or managing employee ever:

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

☐ Yes ☐ No

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

☐ Yes ☐ No

C. Had a controlled drug license withdrawn?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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

17. This form requires the original signature of the authorized agent or representative of the facility/agency

____
Title

____
Printed Name

____
Original Signature

____
Date

18. Mail-To /Home Office Information For The Service Location Entered In 12

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

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

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

c. E-mail address:

d. Contact Name/Title:

Name: ______________________________ Title: ______________________________

e. Business Phone: (   )

f. Toll-Free Phone (   )

g. Fax Number: (   )

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

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

c. E-mail address:

d. Contact Name/Title:

Name: ______________________________ Title: ______________________________

e. Business Phone: (   )

f. Toll-Free Phone (   )

g. Fax Number: (   )

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Provider Agreement for CHIP Providers

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

__________________ (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Children’s Health Insurance Program (CHIP). The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the CHIP Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the MCO Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania CHIP Program.
4. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
5. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
   A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and
   B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5–year period ending on the date of the request.
6. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
7. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.
8. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
9. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
10. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider’s participation in the Pennsylvania CHIP Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

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

______________________________________ ______________

Provider Original Signature **Date**

____

Name – Please Type or Print

Provider Disclosure Statement Definitions

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

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

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

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

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

b. Any Medicare or CHIP intermediary or carrier; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcontractor means**:**

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

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

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

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

OWNERSHIP AND CONTROL INTEREST DISCLOSURE

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

Name of disclosing entity: ______________________________

13-digit PROMISe™ Provider Number: ______________________________

Contact Name (for questions on this form): ______________________________

Contact Phone: (_______) _________ - ______________

Contact E-mail Address: ______________________________

Section I: Managing Employee or Agent Disclosure

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

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

Name: ____________________ ____________ ____________________
(First Name) (Middle Name) (Last Name)

Social Security Number: ____________________ Date of Birth: ______________

Address: ______________________________ Suite/Apt: __________

____________________ ____________ ____________ ______
(City) (State) (Zip Code) (+4)

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

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

2. Description of Offense: ______________________________

   ____

   ____

   ____

   ____

Attach separate sheet, if necessary

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

Section II: Ownership and Control

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

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

INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

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

Name: ________________________ ______________ ____
(First Name) (Middle Name) (Last Name)

Social Security Number: _______________________________ Date of Birth: _______________________

Address: ____ Suite/Apt: ____________

______________________________ _______________ _______________ ________
(City) (State) (Zip Code) (+4)

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

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

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

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

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

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

Name: ______________________________ Relationship: _______________________________
Attach separate sheet, if necessary

Section II: (cont.)

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

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

Name: ______________________________ Relationship: ______________________________

Attach separate sheet, if necessary

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

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

Name: ____

Address: ____ Suite/Apt: ____________

__________________________ ______________ ______________ ________
(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

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

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

5. Description of Offense: ____

____

____

____

____

Attach separate sheet, if necessary

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

Section II: (cont.)

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

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

Name: ____

Federal Tax ID: ______________________________

Address: ____ Suite/Apt: __________

_______________________ ___________ ___________ ______
(City) (State) (Zip Code) (+4)

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

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

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

Address: ____ Suite/Apt: __________

_______________________ ___________ ___________ ______
(City) (State) (Zip Code) (+4)
Attach separate sheet, if necessary

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

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

Name: ____

Address: ____ Suite/Apt: __________

_______________________ ___________ ___________ ______
(City) (State) (Zip Code) (+4)
Attach separate sheet, if necessary

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

Section II: (cont.)

OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

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

Name: ________________________ ______________ ____
(First Name) (Middle Name) (Last Name)

Social Security Number: _______________________________ Date of Birth: _______________________

Address: ____ Suite/Apt: ____________

______________________________ _______________ _______________ ________
(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: ____

Federal Tax ID of Subcontractor: ____

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

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

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

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

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

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

Name: _______________________________ Relationship: ________________________________

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

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

Name: _______________________________ Relationship: ________________________________

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

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

g. Description of Offense: ____

____

____

____

____

Attach separate sheet, if necessary

COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS

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

Name: ____

Federal Tax ID: ____

Address: ______________________________________ Suite/Apt: ____________

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

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

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

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

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

COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES

Section II: (cont.)

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

1. a. Name of Subcontractor: ____

   Federal Tax ID of Subcontractor: ____

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

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

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

OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES

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

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

Name: ____

Address: ____ Suite/Apt: ____________

__________________ __________ __________ ______
(City) (State) (Zip Code) (+4)

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

SIGNIFICANT BUSINESS TRANSACTIONS

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

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

Name of Supplier/Subcontractor: ____

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

Address: ____ Suite/Apt: ____________

__________________ __________ __________ ______
(City) (State) (Zip Code) (+4)

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

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

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

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

Name: ______________________ ______________ ______________________________
(First Name) (Middle Name) (Last Name)

Social Security Number: ______________________________ Date of Birth: ______________________

Address: ____ Suite/Apt: ____________

______________________________ ______________ ______________ ________
(City) (State) (Zip Code) (+4)

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

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

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

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

   Description of Offense: ____

   ____

   ____

   ____

   ____

   Attach separate sheet, if necessary

****<u>COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS</u>****

Attachment 1

Additional Service Location Address:

NOTE: A Service Location is defined as a physical street address where one or more practitioners:
1.) Maintain an office, 2.) Hold office hours/set appointments, and 3.) Render services.

A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.

Each Service Location must be enrolled separately. To add ADDITIONAL service locations, copy and complete this page as needed for each location you wish to add.

1. Service Location Address:

   Street: ______________________________ Room/Suite: ____________________

   City: ____________________ State: ____ Zip: __ __ __ __ __ - __ __ __ __ (9 digits) County: ____________

   Business Phone: ( ) _______ - ____________ Fax Number: ( ) ________ - ____________

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

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

Screening State	Screening Contact Phone Number	Screening Contact Email Address

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

   If Mail-to and/or Home Office are different from above address, refer to question 18.

2. Specialty(s) and Code(s), if applicable:

   Specialty: ____________________

   Code: ____________________

3. Sub-Specialty(s) and Code(s), if applicable:

   Sub-Specialty(s): ____________________

   Code Number(s): ___ ___ ___ / ___ ___ ___

4. If the taxonomy(s) for this service location differ from the service location identified on page 6, item 12, please provide the taxonomy(s) for this particular service location:

   Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

   Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

5. Provider Eligibility Program (PEP): Refer to PEP descriptions included in the instructions. **Choose at least 1 PEP.**

   a. CHPPR

6. Are a CLIA certificate and a Dept. of Health Lab License associated with this Service Location?

   NOTE: CLIA and DOH Laboratory Permit are only required for Provider Type 28 (Laboratory).

   ☐ Yes ☐ No **If YES, please provide a copy of both with this application.**

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

Did you remember to…?

- ❑ **USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.**
- ❑ **Complete all spaces** as required on the application with either the correct information or N/A.
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ If there are more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- ❑ Indicate ***one*** **primary** provider type, provider specialty and sub-specialty, as applicable.
- ❑ Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- ❑ Include corporation papers from the Department of State Corporation Bureau, a copy of the business partnership agreement, and/or proof of tax exemption status, if applicable.
- ❑ If applicable, **include a copy** of the:
  - ❑ Professional license
  - ❑ CLIA certificate and Dept. of Health Lab Permit if applicable (only required for independent clinical laboratory enrollment).
  - ❑ Permit from the Department of Health and the Department of Insurance
  - ❑ Any other certification, license, or permit that applies.
- ❑ Include a legible copy of the **DEA certificate**, if applicable.
- ❑ Enter **at least 1** Provider Eligibility Program (PEP).
- ❑ Only the **representative of the facility/agency applying for enrollment** can sign and date **Page 8 and Provider Agreement. Signature stamp not accepted.**

When completed, review the "Did You Remember…?" Checklist included with the application.
Return the application and other documentation TO:

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