Requirements for Provider Type 08 - Clinic

Specialty Code

- 074 – Mobile Mental Health Treatment
- 082 – Independent Medical/Surgical Clinic
- 083 – Family Planning Clinic
- 084 – Methadone Maintenance
- 086 – Dental Clinic
- 110 – Psychiatric Outpatient
- 163 – Nurse Family Partnership
- 184 – Outpatient Drug and Alcohol Clinic
- 370 – Tobacco Cessation

Provider Eligibility Program (PEP)

- Fee-for-Service
- Healthy Beginnings + (can be associated with Independent Medical/Surgical Clinics 08-082 only)

Required Documents for Provider Type 08:

The following documents and supporting information are required by the Bureau of Fee-For-Service Programs to enroll any 08 Specialty type (please ensure all documents are legible):

- Completed application for the enrollment of a Facility/Agency—application must include:
    - Signed Provider Agreement with original signature of an authorized representative;
    - Completed Ownership or Control Interest Disclosure form; and
    - If the application is for an **Independent Medical/Surgical Clinic (08-082)** submit the supplements that follow this requirements page
- Signed statement by the clinic Medical Director indicating affiliation with the clinic (see sample on next page)
    - The Medical Director must be a PA Medicaid-participating physician; and
    - A current copy of the Department of State license must accompany the letter
- Documentation generated by IRS showing both the Provider's legal name and FEIN—documentation must come from IRS; this Department does not accept W-9s
- If Provider is tax-exempt, submit IRS 501 (c)(3) letter confirming this status
- If application is for an Out-of-State Provider, submit proof of current home state Medicaid participation

- Copy of Corporation papers issued by Department of State Corporation Bureau or business partnership agreement
- If Provider operates under a fictitious name, submit copy of D/B/A filing with Department of State Corporation Bureau
- Clinical Laboratory Improvement Amendments (CLIA) certificate and PA Department of Health clinical lab permit, if applicable – *note that the PA DOH clinical lab permit requirement applies to both In-State and Out-of-State providers*

Psychiatric Outpatient Clinics (08-110) must submit copy of Certificate of Compliance issued by Department of Human Services. If applying for the 074 specialty (Mobile Mental Health Treatment), a copy of the service description approval granted by OMHSAS must accompany the application.

Drug and Alcohol Clinics (08-184) must submit copy of license issued by the Department of Drug and Alcohol Programs.

The following is a sample Medical Director Letter to be used for illustrative purposes.

_ _/_ _/_ _ _ _

I, Physician's Name, serve as the Medical Director of Name of Enrolling Clinic, located at Street Address. I am a licensed physician who participates in the Pennsylvania Medicaid Program, and my Provider ID number is: _ _ _ _ _ _ _ _ _. Attached is a copy of my current Department of State license.

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Original Signature of Medical Director

Independent Medical/Surgical Clinics (08-082) should apply online via our Electronic Provider Portal at https://provider.enrollment.dpw.state.pa.us . All other Specialties are encouraged to apply via the Provider Portal as well. If circumstances do not allow online submission, send the application and all documents to:

DHS Provider Enrollment

PO Box 8045

Harrisburg, PA 17105-8045

Fax: (717) 265-8284

E-mail: RA-ProvApp@pa.gov

ADDITIONAL INFORMATION FOR INDEPENDENT MEDICAL CLINIC ONLY

1. CLINIC NAME AND ADDRESS:

Name:

Street Address:

City: **State:** **Zip Code:**

2. TYPE OF STATE OR FEDERAL FUNDS RECEIVING OR INITIAL STARTUP FUNDS RECEIVED:

INITIAL START UP FUNDS RECEIVED/CURRENT FUNDS RECEIVING

Fund Type	State or Federal Funds (Please check one)	Amount Received
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____

3. DOES CLINIC PROVIDE COMPREHENSIVE MEDICAL SERVICES FOR A MINIMUM OF FORTY (40) HOURS PER WEEK?

❑ YES ❑ NO

4. ARE SERVICES PROVIDED DIRECTLY BY A PHYSICIAN OR UNDER THE SUPERVISION OF A PHYSICIAN DURING SCHEDULED HOURS OF OPERATION?

❑ YES ❑ NO

5. IF A PHYSICIAN DOES NOT PROVIDE THE SERVICES DIRECTLY, ARE SERVICES PROVIDED BY A CERTIFIED REGISTERED NURSE PRACTITIONER OR A PHYSICIAN ASSISTANT DURING SCHEDULED HOURS OR OPERATION?

❑ YES ❑ NO

6. LIST OF PHYSICIANS, CRNPs AND PHYSICIAN ASSISTANTS WHO STAFF THE CLINIC:

Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**

7. DO YOU HAVE A CURRENT FEE SCHEDULE FOR BILLING ALL THIRD PARTY AND PRIVATE PAYERS?

☐ YES ☐ NO

8. WHAT IS YOUR LOWEST CHARGE PER VISIT?

$ _____

9. DO YOU LIMIT THE NUMBER OF PATIENTS YOU SERVE BY VIRTUE OF PAYMENT SOURCE?

☐ YES ☐ NO

10. INCLUDE A STATEMENT CONFIRMING THE PROCEDURE THE CLINIC FOLLOWS FOR A PATIENT REFERRAL PROCESS THAT ENSURES FOLLOW-UP TREATMENT BY OTHER PHYSICIANS OR APPROPRIATE SPECIALISTS.

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11. INCLUDE A STATEMENT THAT THE CLINIC PROVIDES DIRECT EMERGENCY MEDICAL CARE, THROUGH FORMAL AGREEMENTS, AND PROVIDES FOR ACCESS TO HEALTH CARE FOR MEDICAL EMERGENCIES DURING AND AFTER THE CLINIC'S REGULARLY SCHEDULED HOURS.

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