Print Form

COLORADO

MEDICAL ASSISTANCE PROGRAM

RENDERING PROVIDER APPLICATION

Individuals who complete this application must affiliate to a billing group, cannot directly bill the Colorado Medical Assistance Program and will not receive direct reimbursement.

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

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REGISTERED NURSES MUST COMPLETE

Name and Individual Information

All applicants must complete

1 Individual Information

Individual practitioners must enroll using the name shown on their social security card. All individual practitioners who render services must be enrolled. (If payments for services are to be made to a group practice, partnership, or corporation, then the group, partnership, or corporation must enroll and obtain a Colorado Medical Assistance Program provider number to be used for submitting claims as the billing provider.)

Last Name _____ First Name _____ M.I. ____ Title/Degree _____

Social Security Number _____ Date of Birth _____

2 Medicaid Participation

Are you currently enrolled in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states? _____

Are you currently applying for enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states? _____

Have you ever been denied enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states and when? _____

Has your enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated?
Yes ☐ No ☐ If Yes, which states and when? _____

3 Backdate Request

Please check if you have seen Colorado Medical Assistance clients within the past 120 days.
☐ *(Checking this box does not guarantee approval.)*

This space for fiscal agent use.

Address Information

All applicants must complete

4 Service Location Address & Phone Information

Provide the street address of the location where services will be rendered.

Street Address (must be street address)

City | County | State | Zip

( ) Voice Telephone Number

( ) Fax Telephone Number

5 Billing Office Address & Phone Information

Complete the following information if the billing office address is different from service location address.

click here if same as Service Location

Street Address; PO Box

City | County | State | Zip

( ) Voice Telephone Number

( ) Fax Telephone Number

6 Mailing Address & Phone Information

Complete the following information if the mailing office address is different from service location address. Special mailings (if any) will be sent to this address if different from the service location address.

click here if same as Billing Office

Service Location

Street Address; PO Box

City | County | State | Zip

( ) Voice Telephone Number

( ) Fax Telephone Number

7 Faxback Eligibility Telephone Number

Faxback eligibility allows providers to verify eligibility by telephone and, after hearing the information spoken, receive a fax of the information. If you wish to use this service, your fax telephone number must be recorded on your provider enrollment record. Please identify the telephone number where the faxback eligibility report should be sent. Only a single faxback number can be recorded.

Faxback telephone number ( )

Provider Type, Licensure and Specialty Information

All applicants must complete

8 Provider Type

From the list below, identify the provider type (refer to the provider type listing in Appendix A) appropriate for this application. You must complete a separate application for each provider type (check only one box). If you do not find the appropriate provider type on the list below, you may not be eligible to enroll in the Medical Assistance Program at this time. Please call Provider Services at 1-800-237-0757 for assistance and further directions.

Audiologist (19) ☐
- Deaf and Hard of Hearing ☐

Dental
- Dentist (04) ☐
- Orthodontist (04), Specialty (63) ☐
- Dental Hygienist (04), Specialty (66) ☐

Nurse Anesthetist, CRNA (40) ☐

Nurse-Midwife (22) ☐

Nurse Practitioner (41) ☐

Nurse, Registered (24) ☐

Optometrist (07) ☐

Physician Assistant (39) ☐

Physician
- M.D. (05) ☐
- D.O. (26) ☐

Podiatrist (06) ☐

Psychologist, PhD. (37) ☐

Psychologist, MA Level (38) ☐
(LCSW, LMFT, LPC)

Residential Child Care Facility (RCCF)
- M.D. (05) ☐
- D.O. (26) ☐
- Psychologist, PhD. (37) ☐
- Licensed Mental Health Practitioner (38) ☐

Therapist
- Occupational (28) ☐
- Physical (17) ☐
- Speech (27) ☐

9 Licensure

Provider types requiring license/certification information are identified in Appendix A. Attach a copy of license(s) that include the original effective date and expiration date.

License Number	License Authority/Board	Effective Date	Expiration Date

10 Practitioner Specialty

If board certified, please provide the specialty board certification number, effective date, and expiration date of certification. If needed, provide additional information on the reverse or attach additional pages.

Specialty	Certificate Number	Effective Date	Expiration Date

All applicants must complete

11 Malpractice/ General Liability Insurance

Malpractice/General liability insurance is mandatory under current State and Federal laws.

Medical Malpractice/General Liability Insurance Carrier: _____

12 Other Registration

Applicants with a Taxonomy Number, Drug Enforcement Agency number, and/or National Provider Identification number must complete. Please attach a copy of the registration.

	Number	Begin Date	End Date
Taxonomy Number ➡			
DEA Number ➡			
NPI Number ➡			

All applicants must complete

Ownership/Controlling Interest and Conviction Disclosure

13

Privacy Act Notice Statement
This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the Colorado Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, the Colorado Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or local agencies as appropriate. Providing this information is mandatory to be eligible to enroll as a provider with the Colorado Medical Assistance Program, pursuant to 42 C.F.R. § 433.37. Failure to submit the requested information may result in a denial of enrollment as a provider and issuance of the provider number, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Colorado Medical Assistance Program.

Ownership/Controlling Interest and Conviction Disclosure
Disclosure of information regarding ownership and control and on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services programs is required by the Centers for Medicare and Medicaid Services and the Colorado Department of Health Care Policy and Financing pursuant to regulations found at 42 CFR § 455.100 through 42 CFR § 455.106. The following disclosures must be made to Colorado Medicaid utilizing this form:

a. **Disclosing entities, fiscal agents and managed care entities** (see definitions) must disclose the information required in **Field A**, **Field B, Field C, Field D** and **Field E.** If not applicable check the box provided. All fields must be completed.

b. **All entities** must complete **Field F.** If there is not any person which has an ownership or control interest in the provider, is an agent of the provider or is a managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, then check the box indicating "None".

Entity completing document is:

☐ Provider ☐ Disclosing entity ☐ Other Disclosing entity ☐ Fiscal Agent ☐ Managed care entity

A. List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more. Corporations, LLC, Non-Profits must list Board of Directors and government agencies must list local management structure. Corporate entities must list, as applicable, primary business address, every business location, and P.O. Box address. *If more space is needed attach a separate list including the required information*.

☐ I am an individual using my SSN for enrollment and ownership/control interest does not apply.

Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		

All applicants must complete

B. List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person or entity with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. *If more space is needed attach a separate list including the required information.*

☐ None

Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		
Full Name		Address	% Interest
SSN/EIN	DOB		

C. Are any of the persons mentioned in Field **A** related to one another as a spouse, parent, child, or sibling? *If more space is needed attach a separate list including the required information.*

☐ Yes ☐ No If yes, provide the name, Social Security Number, date of birth and state the relationship.

Name (First, Middle Initial, Last)		Relationship, name and SSN of relation
SSN	DOB	☐ Spouse ☐ Parent ☐ Child ☐ Sibling
Name (First, Middle Initial, Last)		Relationship, name and SSN of relation
SSN	DOB	☐ Spouse ☐ Parent ☐ Child ☐ Sibling
Name (First, Middle Initial, Last)		Relationship, name and SSN of relation
SSN	DOB	☐ Spouse ☐ Parent ☐ Child ☐ Sibling
Name (First, Middle Initial, Last)		Relationship, name and SSN of relation
SSN	DOB	☐ Spouse ☐ Parent ☐ Child ☐ Sibling

All applicants must complete

D. List any person who holds a position of managing employee within the disclosing entity, fiscal agent or managed care entity. *If more space is needed attach a separate sheet with the required information.*

☐ None

Name (First, Middle Initial, Last)		Address
SSN	DOB	
Name (First, Middle Initial, Last)		Address
SSN	DOB	
Name (First, Middle Initial, Last)		Address
SSN	DOB	
Name (First, Middle Initial, Last)		Address
SSN	DOB	

E. Does any person, business, organization or corporation with an ownership or control interest (identified in Field **A**) have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity? *If more space is needed attach a separate sheet with the required information.*

☐ No

Full Name		Other Provider Name and SSN/EIN	% Interest
SSN/EIN	DOB		
Full Name		Other Provider Name and SSN/EIN	% Interest
SSN/EIN	DOB		
Full Name		Other Provider Name and SSN/EIN	% Interest
SSN/EIN	DOB		

F. List any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs. *If more space is needed attach a separate sheet with the required information.*

☐ None

Full Name		Conviction Date, Offense and Jurisdiction
SSN/EIN	DOB	
Full Name		Conviction Date, Offense and Jurisdiction
SSN/EIN	DOB	
Full Name		Conviction Date, Offense and Jurisdiction
SSN/EIN	DOB	

42 C.F.R. § 455.101 Definitions

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

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

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX 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);

(b) Any Medicare 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 or title XX of the Act.

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

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they 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. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

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 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

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

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

(f) Is a partner in a 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 percent 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 Medicaid (e.g., a commercial laundry, a manufacturer of 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.

42 CFR § 455.102 Determination of ownership or control percentages

(a) ***Indirect ownership interest.*** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) ***Person with an ownership or control interest.*** In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

All applicants must complete.

14 Affiliations

An affiliation is the relationship between an individual provider (non billing) who is associated with a billing group (facility, agency or clinic) in order to allow the billing group to submit claims on behalf of the individual provider. For example a dentist (non billing & enrolled using SSN) would affiliate to a dental clinic (billing entity enrolled using EIN), or a physician (non billing & enrolled using SSN) would affiliate to a health clinic (billing entity enrolled using EIN). This will avoid claim payments reported to the IRS under the individual's social security number.

1. *Individual physicians working in IHS clinics are included.*
2. Individual applicants must list all groups or clinics that may submit claims on their behalf. Individuals must have at least one enrolled billing entity affiliated in order to enroll with the Colorado Medical Assistance Program.

Please identify each affiliation by name, Medical Assistance Program provider number, and NPI. Providers are required to notify Medical Assistance Program Provider Enrollment in writing of any change in affiliation information.

	Name	Medical Assistance Program Provider Number	NPI
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Contact Information

If there are questions concerning this application, who may be contacted if the person submitting the application is not the applicant?

Contact Name: _____

Contact Phone Number and/or Email Address: _____

All applicants must complete

Note: All those providers with a current Colorado Medical Assistance Program Provider ID number, or those providers submitting an application to become a Colorado Medical Assistance Program Provider MUST EXECUTE AND RETURN this Provider Participation Agreement.

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is entered into by and between the Colorado Department of Health Care Policy and Financing ("Department"), it's Fiscal Agent for the Colorado Medical Assistance Program, and

_____ , _____ ,

(Provider Name) (Indicate 'Pending' for new enrollment or provider number if previously enrolled)

("Provider"), collectively "the Parties." This Agreement is entered into in order to define Department expectations of providers who perform services and submit billing, transactions, and/or data to the Colorado Medical Assistance Program. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. This Agreement is to be considered in conjunction with the Provider Enrollment Form, if necessarily completed.

RECITALS

A. The Colorado Department of Health Care Policy and Financing is the single state agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. The Fiscal Agent for the Colorado Medical Assistance Program has developed, on behalf of the Colorado Department of Health Care Policy and Financing, a paperless transaction system that will process Colorado Medical Assistance Program electronic transactions submitted through the designated electronic media.

C. The contracted Fiscal Agent for the Colorado Department of Health Care Policy and Financing is responsible for administration of the Colorado Medical Assistance Program. Although the Fiscal Agent for the Colorado Medical Assistance Program operates the computer system translator through which electronic transactions flow, the Department retains ownership of the data itself. Providers access the pipeline network through various means, over which the transmission of electronic data occurs. Accordingly, providers are required to transport data to and from the Fiscal Agent for the Colorado Medical Assistance Program.

D. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

E. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

F. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the Colorado Medical Assistance Program. As consideration for acceptance as an enrolled provider in the Colorado Medical Assistance Program, the Provider certifies and agrees to the terms and conditions set forth below.

All applicants must complete

DEFINITIONS

For the purpose of this Agreement:

A. "Colorado Department of Health Care Policy and Financing" means the Colorado State governmental agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. "Standard" is defined in 45 C.F.R. § 160.103.

C. "Provider" refers to any health care provider with a current Colorado Medical Assistance Program Provider ID number or any health care provider submitting an application to become a Colorado Medical Assistance Program Provider. "Provider" also includes all agents, subcontractors, or employees of a Colorado Medical Assistance Program Provider.

D. "Transaction" is defined in 45 C.F.R. § 160.103.

E. "Transactions and Code Set Regulations" mean those regulations governing the transmission of certain health claims transactions as promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. Parts 160 and 162.

PROVIDER PARTICIPATION

A. Provider shall comply with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and Department rules. Provider shall limit the use or disclosure of information/data concerning Colorado Medical Assistance Program clients to the purposes directly connected with the administration of the Colorado Medical Assistance Program.

B. Provider shall accept full legal responsibility for all claims submitted under the Provider's Colorado Medical Assistance Program ID number to the Colorado Medical Assistance Program and shall comply with all federal and state civil and criminal statutes, regulations and rules relating to the delivery of benefits to eligible individuals and to the submission of claims for such benefits. Provider understands that non-compliance could result in no payment for services rendered.

C. Provider shall request payment only for those services which are medically necessary or considered covered preventive services, and rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision. Provider shall submit claims only for those benefits provided by health care personnel who meet the professional qualifications established by the State. Provider understands that any misrepresentation or falsification by another may result in fines and/or imprisonment under state or federal law.

D. Provider shall maintain records that fully and accurately disclose the nature and extent of benefits provided to eligible clients/patients in accordance with the regulations of the Department. Provider shall maintain licensure and/or certification granted by the State licensing agency that regulates the services that are provided, and shall make disclosure of ownership and provide access to medical records and billing information to the Department, or its designees, as required by federal and state laws and regulations.

E. Provider shall maintain records for six (6) years unless an additional retention period is required under state or federal regulations, such as an audit started before the six (6) year period ended or based on a specific contract between the Provider and the Department.

F. The US Department of Health and Human Services, the Department, or the State Attorney General's Medicaid Fraud Control Unit, or their designees, has the right to audit and confirm for any purpose any information submitted by the Provider. Provider shall furnish information about submitted claims, any claim documentation records, and original source documentation; including provider and patient signatures, medical and financial records in the Provider's office or any other place, and any other relevant information upon request. Any and all incorrect payments discovered as a result of an audit will be adjusted or fully recovered according to the applicable provisions of the Social Security Act, as amended, federal or state laws, regulations, and guidelines.

G. Provider shall accept as payment in full, amounts paid in accordance with schedules established by the Department. Provider shall not bill supplemental charges to the client, except for amounts designated as co-payments by the Department. Provider shall not bill the client for any covered items or services that are reimbursable under the rules and regulations of the Department, or for any items or services that are not reimbursable but would have been had the Provider complied with the rules and regulations of the Department. Provider shall record all payments received or applied from any other sources on the claim.

H. Provider certifies that items and services provided will be available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, handicap, or national origin. Provider hereby certifies compliance with Section 504 of the Rehabilitation Act of 1973 which provides that, "no otherwise qualified individual with a disability...shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..."

I. If, at any time from the date of this Agreement, the Department determines that Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, Provider may be suspended from participation in the Medical Assistance Program, and may be subjected to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

J. Department payment by electronic funds transfer (EFT) and advisement by deposit notice or remittance statement represents Provider's confirmation that funds were accepted for services rendered and billed.

K. Provider, and person signing the claim or submitting electronic claims on Provider's behalf, understands that failure to comply with any of the above in a true and accurate manner will result in any available administrative or criminal action available to the Department, the State Attorney General's Medicaid Fraud Control Unit, or other government agencies. The knowing submission of false claims or causing another to submit false claims may subject the persons responsible to criminal charges, civil penalties, and/or forfeitures.

L. Pursuant to federal regulations at 42 CFR § 455.105, provider shall submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request; and, (2) 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. *Significant business transaction* means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000.00 and 5 percent of a provider's total operating expenses.

M. Pursuant to federal regulations at 42 CFR § 455.434, provider shall consent to criminal background checks including fingerprinting when required to do so under state law or by the level of screening based on risk of fraud, waste, or abuse as determined for the category of the provider.

N. Pursuant to federal regulations at 42 CFR § 455.432, provider shall allow the Centers for Medicare & Medicaid Services (CMS), its agents, its designated contractors, State Attorney General's Medicaid Fraud Control Unit, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.

O. Pursuant to federal regulations at 42 CFR § 431.107(b)(4), hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs shall comply with the advance directives requirements specified in 42 CFR part 489, subpart I and 42 CFR § 417.436(d).

P. Pursuant to federal statute at 42 U.S.C. § 1396a(68), any entity that makes or receives annual payments of at least $5,000,000.00 under the State Plan, as a condition of receiving such payments, shall establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)); include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

Q. Pursuant to federal regulations at 42 CFR § 431.107(b)(5), provider shall furnish to the Department its National Provider Identifier (NPI) (if eligible for an NPI) and include it on all claims submitted under the Medicaid program.

R. Pursuant to federal regulations at 42 CFR § 455.106, before renewal of or entering into a provider agreement, or at any time upon written request by the Department, the provider shall disclose the identity of any person who: (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

S. At any time during the course of this Agreement, the Provider shall notify the Department of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty five (35) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in: ownership; disclosures; licensure; federal tax identification number; bankruptcy; any change in address, telephone number, or email address; and criminal convictions under 42 CFR § 455.106.

GENERAL ELECTRONIC DATA INTERCHANGE TERMS AND CONDITIONS

(only applicable to those providers submitting and receiving data electronically)

A. The Parties shall submit claims and exchange data electronically using only those approved Transaction types and formats (versions) as selected by Provider within the Provider Enrollment Form.

B. For electronic claims, Provider shall ensure that all required provider and patient signatures, including, where applicable, appropriate signatures on behalf of the patient, and required physician certifications are on file in the Provider's office.

C. Transactions/documents will be transmitted electronically either directly or through a contracted third-party service provider, such as a vendor, billing agent, or clearinghouse. Provider may modify its election to use, not use, or change a third-party service provider by updating the Provider Enrollment Form. Provider will be responsible for the costs of any third-party service provider with which it contracts, and shall ensure that any third-party service provider contracted will properly institute and adhere to those procedures reasonably calculated to provide appropriate levels of security for the authorized transmission of data, and protection from improper access. No Party accepts responsibility for technical or operational difficulties that arise out of third-party service providers' business obligations and requirements that undermine the Transaction exchange between Provider and the Fiscal Agent for the Colorado Medical Assistance Program.

D. The Parties shall not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically, as per 45 C.F.R. § 162.915.

E. The Parties shall not add any data elements or segments to the maximum defined data set, as per 45 C.F.R. § 162.915.

F. The Parties shall not use any code or data elements that are either marked "not used" in a Standard's implementation specification or are not in the Standard's implementation specification(s), as per 45 C.F.R. § 162.915.

G. The Parties shall not change the meaning or intent of a Standard's implementation specification(s), as per 45 C.F.R. § 162.915.

H. The Fiscal Agent for the Colorado Medical Assistance Program shall accept Transactions from Provider according to the Provider Enrollment Form, but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the Provider Enrollment Form. The Fiscal Agent for the Colorado Medical Assistance Program may return Provider to a test status if Provider repeatedly submits Transactions that do not meet the criteria set forth in the Provider Enrollment Form or if Provider repeatedly submits inaccurate or incomplete Transactions to the Fiscal Agent for the Colorado Medical Assistance Program.

I. Provider understands that the Fiscal Agent for the Colorado Medical Assistance Program or others may request an exception from the Transaction and Code Set Regulations from the U.S. Department of Health and Human Services. If an exception is granted, Provider shall participate fully with the Fiscal Agent for the Colorado Medical Assistance Program in the testing, verification, and implementation of a modification to a Transaction affected by the change.

J. Provider and the Fiscal Agent for the Colorado Medical Assistance Program shall keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage, as per 45 C.F.R. § 162.925(c)(2).

K. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving Party. Once transmissions are properly received, the receiving Party shall promptly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received Transactions. Each Party shall subject information to a virus check before transmission to the other Party.

L. The Fiscal Agent for the Colorado Medical Assistance Program may publish data clarifications ("Companion Guides") to complement each Implementation Guide. HIPAA Implementation Guides are available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Companion Guides are available on the Department's website at colorado.gov/hcpf➡Provider Services➡Specifications.

ELECTRONIC CONFIDENTIALITY, PRIVACY AND SECURITY

(only applicable to those providers submitting and receiving data electronically)

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Regulations (45 C.F.R. Parts 160 and 164) apply to all health plans, health care clearinghouses, and health care providers that transmit protected health information in electronic transactions; and extends to any business associate working on behalf of a covered entity. As such, it is expected that all Parties will implement and maintain appropriate policies, procedures, and mechanisms to protect the privacy and security of protected health information that is maintained by, and transmitted between, the Parties.

B. Any electronic protected health information furnished to one Party by any other Party will be used only as authorized under the terms and conditions of this Agreement and the Provider Enrollment Form, and may not be further disclosed. The Parties shall establish appropriate administrative, technical, procedural, and physical safeguards to ensure the confidentiality, integrity, and availability of all electronic protected health information that is created, received, maintained, or transmitted as part of this Agreement. Provider shall obtain satisfactory assurance and documentation thereof, as required by 45 C.F.R. § 164.502(e), from any business associate with whom it contracts, and any subcontractors thereof, that all protected health information covered by this Agreement will be appropriately safeguarded.

C. In the event the Department determines, or has a reasonable belief that Provider has made or may have made disclosure of Colorado Medical Assistance Program client protected health information that is not authorized by this Agreement, the Provider Enrollment Form, or other written Department authorization, the Department, in its sole discretion, may require the Fiscal Agent for the Colorado Medical Assistance Program and/or Provider to: (a) promptly investigate and report to the Department determinations regarding any alleged or actual unauthorized disclosure; (b) promptly resolve any problems identified by the investigation; (c) submit a formal written response to an allegation of unauthorized disclosure; (d) submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and/or (e) return data to the Department.

ASSIGNMENT OF AGREEMENT

A. This Agreement is entered into solely between, and may be enforced only by the Parties. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of the Parties to any third party.

B. No Party may assign this Agreement without the prior written consent of the Department, and such consent may not be unreasonably withheld.

MODIFICATIONS

A. This Agreement contains the entire agreement between the Parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information/data. Any change to this Agreement will be effective only when set forth in writing and executed by all Parties.

DISPUTES AND LIMITATION OF LIABILITY

A. This Agreement will be interpreted consistently with all applicable federal and state laws. In the event of a conflict between applicable laws, the more stringent law will be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement will be governed by and construed in accordance with Colorado law, exclusive of conflicts of law principles. The exclusive jurisdiction for any legal proceeding regarding this agreement shall be in the courts of the State of Colorado and the Parties hereby expressly submit to such jurisdiction.

B. Parties shall use reasonable efforts to assure that the information – data, electronic files and documents supplied hereunder – are accurate. However, Provider shall indemnify, save, and hold harmless the Department, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the Provider, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement.

C. Notwithstanding anything herein to the contrary, no term or condition shall be deemed, construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or provisions, of the "Colorado Governmental Immunity Act", 24-10-101, et seq., C.R.S., as now or hereafter amended ("Immunity Act"), nor of the Risk Management self-insurance statutes at 24-30-1501, et seq., C.R.S., as now or hereafter amended ("Risk Management Act"). The Parties understand and agree that the liability of the State of Colorado, its departments, institutions, agencies, boards, officials and employees is controlled and limited by the provisions of the Immunity Act and the Risk Management Act, as now or hereafter amended. Any provision of this Agreement, whether or not incorporated herein by reference, shall be controlled, limited, and otherwise modified so as to limit any liability of the State to the above cited laws. In no event will the State be liable for any special, indirect, or consequential damages, even if the State has been advised of the possibility thereof.

D. DISCLAIMER OF WARRANTIES. THE PARTIES HEREBY EXCLUDE ALL EXPRESS AND IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY AND THE IMPLIED WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE. THERE ARE NO WARRANTIES WHICH EXTEND BEYOND THE DESCRIPTION OF THE FACE OF THIS AGREEMENT.

E. Provider warrants and represents that at the time of entering into this Agreement, neither Provider nor any of its employees, contractors, subcontractors or agents are identified on the HHS/OIG List of Excluded Individuals/Entities (available at https://oig.hhs.gov/ ➡ Exclusions Database). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to immediately notify the Department of such ineligible person status and within ten days of such notice, remove such individual from responsibility for, or involvement with the Providers business operations related to this Agreement.

TERMINATION

A. This Agreement shall remain in effect until terminated by any Party with not less than thirty (30) days prior written notice to the other Parties. Such notice shall specify the effective date of termination. In the event of a material breach of this Agreement by Provider, as determined by the Department, the Department may terminate the Agreement by giving written notice to the breaching Provider. The breaching Provider shall have thirty (30) days to fully cure the breach. If the breach is not cured within thirty (30) days after the written notice is received by the breaching Provider, this Agreement shall automatically and immediately terminate.

B. This Agreement may be terminated by the Department if the contract between the Department and the Fiscal Agent for the Colorado Medical Assistance Program expires or terminates. Provider enrollment records will survive assignment of a new Department fiscal agent unless provider re-enrollment is explicitly initiated by the Department.

TERM OF AGREEMENT

A. This Agreement is effective for the entire term of enrollment. This Agreement shall continue until terminated.

All applicants must complete

PROVIDER SIGNATURE PAGE

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.

I certify by my signature below that I am fully authorized to sign and execute this Agreement on behalf of Provider; and that I have read, understand, certify, and agree to all the statements made above in all parts of this Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a Colorado Medical Assistance Program Provider, and/or may be prosecuted under applicable federal and state laws.

Provider

The individual applicant must personally sign the provider participation agreement. A representative may not sign for the applicant. Please print and sign.

By: _____

Provider/Provider Representative Signature

Name: _____

Provider Name (please print)

Date: _____

Practitioners and Practitioner Groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual practitioners must be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have its own provider number. The group provider number must be identified as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Certified Nurse-Midwife (22)	Attach state nursing license and certificate from American College of Nurse-Midwives.
Clinic, Professional Corporation, Partnership, or Sole Proprietorship (16)	At least one Colorado Medical Assistance Program-enrolled practitioner must be listed. Requires CLIA certificate for laboratory services if applicable.
Optometrist (07)	Attach state optometry license.
Physician (MD) (05) and (DO) (26)	Attach state medical license and include specialty certification if applicable. Requires CLIA certificate for laboratory services if applicable.
Podiatrist (06)	Attach state podiatry license. Requires CLIA certificate for laboratory services if applicable.
Non-Physician Practitioner Group (25)	At least one Medical Assistance Program enrolled non-physician practitioner must be listed (OTs and PTs excluded).

On premise supervision for non-physician practitioners (Registered Nurses only)

Requires on premise supervision when services are provided and payments must be made to a physician (MD), advanced practice nurse (APN) or clinic. Must identify APN/MD supervisor by name on the separate "On premise supervision for non-physician practitioners" form.

Services/Providers	Licensure & certification submission requirements
Registered Nurse (24)	Attach state nursing license. Submit completed supervision form. Must complete the rendering application and affiliate with a group provider to receive payment.

Non-Physician Practitioners

Services/Providers	Licensure & certification submission requirements
Audiologist (19)	Attach copy of Colorado Audiology License Certification from the American Speech and Health Association or the American Board of Audiology. Proof of registration with State Audiology and Hearing Aid Provider Registration Office.
Certified Registered Nurse Anesthetist (40)	Attach state nursing license and certification by the Council on Nurse Anesthetists.
Doctorate Level Psychologist (37)	Licensed: Attach state psychologist license. Unlicensed: Cannot enroll.
Licensed Mental Health Professional (under Doctorate Level) (38)	Attach state social work license or professional counselor license and proof of education.

Non-Physician Practitioners – (continued)

Services/Providers	Licensure & certification submission requirements
Nurse Practitioner (41)	Attach state Nursing License and one of the following: Pediatric Nurse Practitioner Certificate from National Certification Board of Pediatric Nurse Practitioners or Family Nurse Practitioner Certificate from American Nurse Association.
Occupational Therapist (28)	Attach state occupational therapy license.
Physical Therapist (17)	Attach state physical therapy license.
Physician Assistant (39)	Attach state medical license. Must complete the rendering application and affiliate with a group provider to receive payment.
Speech Therapist (27)	Attach state speech therapy license.

Dental providers and dental groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual dental providers must be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have its own provider number. The group provider number must be identified as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Dental Clinic, Professional Corporation, Partnership, or Sole Proprietorship (47)	Dental clinic ownership must be a licensed dentist or dental hygienist, a political subdivision, or a non-profit corporation. In state dental clinic owners must have a current/active/valid Colorado dental or dental hygienist license. Attach a copy of the license. A non-profit corporation must be in good standing and submit a copy of the Certification of Good Standing issued by the Colorado Secretary of State. At least one Medical Assistance Program enrolled dentist or dental hygienist must be associated with the clinic. Attach a copy of the dental license.
Dentist (04)	Attach a copy of state dental license.
Orthodontist (04), Specialty (63)	Attach a copy of state dental license and certificate of graduation from an American Dental Association Accreditation Commission accredited program in orthodontics.
Dental Hygienist (04), Specialty (66)	Attach a copy of state dental hygiene license.

On premise supervision for non-physician practitioners (Registered Nurses only)

Registered nurses, by state regulation, require on premise supervision and must complete this form to enroll with Colorado Medicaid.

- Registered Nurses (Other than employees of a Certified Health Department* and employees of a Nurse Home Visitor Program (NHVP) site**)

Benefit services by registered nurses must be provided in compliance with the following requirements:

- Services must be performed under the direct and personal supervision of an advanced practice nurse (APN) or physician (MD) who is immediately available when services are provided. This means that the supervising APN/MD must be physically present on the premises when the service is provided.
  - The on premise requirement does not apply to targeted case management provided by registered nurses under the Nurse Home Visitor Program. Registered nurses can provide this service without a supervising APN/MD on premises.
- Services must be ordered by the supervising APN/MD.
- Claims must be submitted through the supervising APN/MD. Registered nurses must look to the supervising or billing APN/MD for compensation.
- The supervising APN/MD Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring provider, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the registered nurse with provider number, as the rendering provider.
- The registered nurse applicant must identify the Colorado Medical Assistance Program enrolled APN/MD(s) who will provide supervision. The supervisor's original signature must be included on the application. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.

* Employees of a certified health agency do not require on premise supervision. Complete this form by identifying the agency's provider by name and provider number and write "Certified Health Agency" on line one in the space for the supervising provider's signature.

** Employees of a Nurse Home Visitor Program site providing case management services do not require on premise supervision. Complete this form by checking the box to attest that enrollment is for the NHVP, sign and date in the space provided below.

	Supervising APN/MD Name	Colorado Medical Assistance Program Provider Number	Supervising APN/MD's Original Signature
1.			
2.			
3.			
4.			

☐ I am applying to render targeted case management services to Medicaid clients through the Nurse Home Visitor Program.

The name of the program site is_____.

Name	Signature	Date

Please return the completed application to the following address:

Colorado Medical Assistance Program
Provider Services
P.O. Box 1100
Denver, CO 80201-1100

Thank you for your interest and submitting an enrollment application.

Click Here to Print Form