Florida Medicaid Provider Enrollment Application

- **Any person or entity that wants to be paid for rendering medical, medical-related and waiver-related services to Medicaid recipients must complete this form.**
- **Use only the current application form. If you are unsure about whether you have the most current form, call the Medicaid fiscal agent at 1-800-289-7799. Option 4.**
- **Please type or print in blue or black ink. Do not use red ink.**
- **Out-of-state providers call the Medicaid fiscal agent at 1-800-289-7799, Option 4 for instructions before completing this form.**

NOTE: Step by step instructions are found in the *Guide for Completing A Medicaid Provider Enrollment Application.*

I. Who Are You and How Do We Reach You?

1. Name of Business or Individual: ______________________________
(An individual's name entered here must also be entered in Question 29.)

2. Doing Business As (D/B/A): ______________________________

3. Tax Identification Number:
(Enter either the SSN or FEIN by which the IRS knows you. The tax id you enter here is what will be reported to the IRS as required by law. If you are individually incorporated, list your FEIN and not your SSN. Do not enter both. Attach a legible copy your SSN card, IRS Form SS-4, 1072, or W-9 as proof of your tax id.)

Social Security Number (SSN): _____ – ____ – ________

OR

Federal Employer Identifier Number (FEIN): ____________________

4. Physical Street Address: ______________________________
(Required)

Building, Suite Number: ______________________________
(or P. O. Box if applicable)

City: ____________________ **State:** ________ **ZIP:** ____________

5. County Name: ______________________________

6. Business Location Telephone Number: (   ) ____________________
Area Code

Business Location Fax Number: (   ) ____________________
Area Code

Contact Person: ______________________________
(List the person who AHCA should contact if there are questions about the application package.)

Contact Person's Telephone Number: (   ) ____________________
Area Code

7. Business E-mail Address: ______________________________
Visit http://www.fdhc.state.fl.us/Medicaid/hipaa/lyrissubscribe.shtml to register for the Florida Medicaid Email Alert System. These automated email alerts are used to keep providers informed of late-breaking Medicaid information.

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

II. What Type Of Provider Are You?

8. Provider Type Code ________

9. Practice Type Code ________

10. Category of Service Code _______ _______ _______ _________

11. Specialty Code

(Any physician adding a specialty code designation of Pediatric Surgery or Urology must also submit a copy of their Board Certification with this application. All other specialists may attest to the following statement.)

"By signing this application, I do hereby certify that I have successfully completed the required post-graduate training in the specialty indicated below. The training was completed at an American Council on Graduate Medical Education or American Osteopathic Association approved program(s)."

Primary Specialty Code _________

Name of Approved Training Program ______________________________

Location of Program ______________________ (City) ________ (ST)

Date(s) Attended ____________ to ____________

Secondary Specialty Code _________

Name of Approved Training Program ______________________________

Location of Program ______________________ (City) ________ (ST)

Date(s) Attended ____________ to ____________

12. License Information

Professional License Number ____________________

Facility License Number ____________________

CLIA License Number ____________________

13. NPI Number ______________________ And / Or **UPI Number** ____________

14. Medicare Number _________________

15. Provider Handbooks: Check here if you wish to receive handbooks by mail ❑

NOTE: Up-to-date Medicaid provider handbooks are available for no charge on the fiscal agent web site (www.mymedicaid-florida.com). Copies of the handbooks will not be mailed to you unless requested above.

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

III. Are You One Of These Provider Types?

(The next four questions pertain only to certain provider types. Please review carefully to determine if you must respond.)

16. Collaboration Agreement for Individual PA and ARNP

(All individual Physician Assistant (PA) and Advanced Registered Nurse Practitioner (ARNP) applicants must complete this section.)

"This signature certifies that the undersigned will collaborate in the provision of medically necessary services provided to Medicaid recipients."

____ M.D. D.O. D.D.S.
Signature: (circle one)

____ ________________
Print Name of Collaborator. License #

17. Ownership Certification for Physician Groups

(Physician group applicants must complete this section. Do not complete for individuals linking to a group.)

The applicant certifies the ownership of the entity as:

- ☐ 50% or more owned by physicians or a not-for-profit hospital, or
- ☐ More than 50% owned by non-physicians or a for-profit hospital.
  ($50,000 Surety Bond required if this box is checked.)

The applicant certifies the location of the entity as:

- ☐ Independently located, or
- ☐ Owned by and located in a hospital, or
- ☐ Located in (not owned by) a hospital
  (If the applicant is located in (not owned by) a hospital, submit letter with original signature from the hospital CEO authorizing privileges.)

18. Home Medical Equipment License Exemption

(Durable Medical Equipment (DME) applicants must complete this section.)

Check the appropriate box if you meet any of the following exemptions:

- ☐ Business that supplies only diabetic monitors and disposable supplies, e.g., diabetic, ostomy, urological or wound care supplies.
- ☐ Orthotics and prosthetic provider licensed under Chapter 468, part XIV, F.S., which sells only orthotics and prosthetics.
- ☐ DME business that is owned by a pharmacy licensed under Chapter 465, F.S.
- ☐ DME business that is owned by a nursing facility, assisted living facility, home health agency, hospice, intermediate care facility, home for special services, or transitional living facility licensed under Chapter 400, F.S.
- ☐ DME business that is owned by a hospital or ambulatory surgical center licensed under Chapter 395, F.S.
- ☐ N/A

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

19. Pharmacy Information

(Pharmacy applicants must answer all sections (a – e) of this question.)

a. Board of Pharmacy Permit

Business Name ____
(as it appears on the permit):

Type of Pharmacy ____________________

License Number ____________________

b. Prescription Department Manager
(The prescription department manager must also be listed in Question 28.)

Print Name: ____

License Number: ____________________

c. DEA Number ____________________

d. Is this facility affiliated with or part of a chain? **Yes** ❐ **No** ❐
*(If **YES**, list chain's name, corporate address and Tax ID)*

Name: ____

Federal Tax ID: ____________________

Corporate Address: ____
____

City: ____________________ ST: __________ ZIP: __________

e. Point of Service (POS)
(If you plan to submit pharmacy claims electronically through a POS device, see Question 22 and then provide the following:)

System Vendor Name ____

System Vendor Certification # ____________________

IV. How Do You Wish To Submit Claims?

20. Group Membership Information for Individual Providers

(Individual providers who will be submitting Medicaid claims under a group number must complete section (a) below. Up to 15 group links are accepted.)

a.

Group Provider Number:	Effective Date:	Group Provider Number:	Effective Date:	Group Provider Number:	Effective Date:

b. Is a group enrollment pending with this application? **Yes** ❐ **No** ❐
(If yes, list name and tax ID of group provider below.)

Group Name: ____

Federal Tax ID: ____________________

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

21. Billing Agent Agreement

"The following billing agent is authorized to submit claims to and follow up with Medicaid and the Medicaid fiscal agent on my behalf. I understand that all payments and payment information are in my name and that this agreement does not exempt me from responsibility for claims filed on my behalf or from established claim filing policies. I further understand that the billing agent must be enrolled in the Medicaid program and is held to the same requirements of confidentiality and access to records that I am, as reflected in my agreement with Medicaid. I will immediately notify the Medicaid fiscal agent of any change in this authorization."

Billing Agent Name: ____

Billing Agent Provider Number: ______________________
(Required)

Billing Agent Address: ____

____

City: ______________________ ST: _______ ZIP: ____________

22. Electronic Claims Submission

Providers who choose to submit claims electronically, including pharmacies that use Point of Service (POS) devices, must be aware that payment of claims will be from federal and state funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws. Further, providers must understand and agree to the following:

- Safeguard the Medicaid program against abuse in the use of electronic claims submission, including POS.
- Correctly enter the claims data, monitor the data and certify that the data entered is correct.
- Assure that the transmission of claims data is restricted to authorized personnel to prevent erroneous payments by the Agency's fiscal agent that might result from carelessness or fraud.
- Have on file the applicable source data to substantiate the claim submitted to the Medicaid program.
- Allow the Agency or any of its designees and representatives of the office of the Auditor General or the Attorney General to review and copy all records, including source documents and data related to information entered through electronic claims submission, including POS.
- Abide by all Federal and State statutes, rules, regulations, and manuals governing the Florida Medicaid program.
- Sign and adhere to all conditions of the Medicaid Provider Agreement and be officially enrolled in the Medicaid program to participate in electronic claims submission, including POS.

In addition, Pharmacy providers who use POS devices to submit claims must understand and agree to the following:

- Maintain the original prescription on file.
- Reverse any claim adjudicated and then not dispensed to a Medicaid recipient. Claim reversals are limited in their use by Medicaid policy.
- Allow the Agency or its representatives to perform audit functions.

Indicate which of the following will be used to submit claims electronically:

❒ **WinAsap** Phone # for Submissions (   ) ______________________
Area Code

❒ **Vendor Software** Vendor Name ______________________

❒ **Billing Agent** Agent's Name and ______________________

Medicaid Provider Number ______________________

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

V. How Do You Wish To Receive Payment?

23. Electronic Remittance Voucher

Allow the entity indicated below to receive remittance vouchers through Internet download from the fiscal agent's Internet website:

❒ Provider **or** ❒ Billing Agent

24. Mailing Address For Payment: ____

(Reimbursement checks and paper remittance vouchers will be sent to this address.) ____

City: ______________________ State: ______ ZIP: ________

25. Payment Method

Choose one of the following payment methods:

- If you are an individual or group provider who will receive direct payment from Medicaid, complete **Option 1, Electronic Funds Transfer (EFT) Agreement.**
- If you are an individual who will NOT receive direct payment from Medicaid, skip Option 1 and complete **Option 2, Electronic Funds Transfer Agreement Exception Request**, to assign your payment to a group provider.

NOTE: If you work for a group AND will also bill separately for yourself, complete Option 1 with *your* personal banking information. *Do not place an employer's information on your individual file.*

Option 1. Electronic Funds Transfer (EFT) Agreement:

"The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the depository bank indicated."

List all individuals authorized to sign on this account:

Print Name	Signature
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

NOTE: All individuals listed above must also be listed in Q.29 and meet Medicaid Enrollment Background Screening Requirements. If this agreement is for an individual provider number, the individual who owns the number MUST sign here. Any future changes to this EFT account will require a signature of an individual authorized as listed below.

Name On Bank Account: ____

Bank Account Number: ______________________

Bank Name: ____

Branch: ____

City: ______________________ ST: _____ ZIP: ________

Bank Telephone #: ( ) ______________________
Area Code

NOTE: A letter from the depository bank verifying the bank transit / ABA routing number, the account number and account name must be attached to this application.

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

Option 2. Electronic Funds Transfer (EFT) Agreement Exception Request:

"I work under group provider number ____________________ and all disbursements made for services performed by myself will be made directly to the group on my behalf. I understand that by requesting this exemption, I will not be able to receive direct disbursements from Medicaid for the services I render, and I will not be able to file Medicaid claims under my individual provider number."

VI. Who Are your Owners And Operators?

26. Change of Ownership

Is this application based on a change of ownership (CHOW)? **Yes** ❒ **No** ❒

(If yes, submit a copy of stock transfer document or bill of sale and complete the following information about the previous owner.)

Name: ______________________________

Provider Number: ____________________

Federal Tax ID: ____________________ Date of CHOW: ____________________

27. Ownership Code ___________

28. Records Custodian(s)

(List a person not an entity.)

a. Medical Records Custodian:

(The Medical Records Custodian must also be entered in Q.29).

Name: ______________________

Phone Number: (   ) ______________________
Area Code

Physical Address of Medical Files ______________________

City/State: ______________________

Zip Code: ______________________

b. Financial Records Custodian:

(The Financial Records Custodian must also be entered in Q.29).

Name: ______________________

Phone Number: (   ) ______________________
Area Code

Physical Address of Financial Files ______________________

City/State: ______________________

Zip Code: ______________________

29. Owner(s) and Operator(s):

All of the individuals listed below **must** submit a completed fingerprint card for background screening to become a Medicaid provider unless they meet one of a few specific exemptions. See the Guide for Completing a Medicaid Provider Enrollment Application for details.

*Name *(* denotes required field)*	Title	*Relationship *(See Note Below)*	*SSN	License #	* % Owner

NOTE: Select one or more from the following list when indicating each owner and operator's relationship to the applicant:

Owner, Officer, Director, Financial Records Custodian (FRC), Medical Records Custodian (MRC), Shareholder, Sub-Contractor, EFT Authorized Individual, Partner, Manager, or Family (Specify Relationship, i.e.; Spouse, Parent, Sibling, or Child).

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

30. Applicant History

(Answer all sections (a – f) of this question.)

Have you, or any of the individuals listed in Question 29, ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony? **Yes ❒** **No ❒**

If yes, list the name(s) of the individuals(s) and provide a copy of the administrative complaint and final disposition.

Name: ______________________________

b. Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state? **Yes ❒** **No ❒**

If yes, list the name(s) of the individual(s) and the date of the action. Provide a copy of the final disposition. Attach documentation from the proper authorities that approved the reinstatement of the license.

Against whom? ______________________________

What date? ______________

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state? **Yes ❒** **No ❒**

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: ______________________________

Provider Number: ______________

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state? **Yes ❒** **No ❒**

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: ______________________________

Provider Number: ______________

e. Owes money to Medicaid or Medicare that has not been paid? **Yes ❒** **No ❒**

If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation.

Name: ______________________________

Provider Number: ______________

f. Have ownership in any other Medicaid enrolled business? **Yes ❒** **No ❒**

If yes, list the name and Medicaid provider number of the other Medicaid enrolled business and the names of all owners of five percent or more of the business. Attach additional pages if necessary.

Name of Other Business: ______________________________

Provider Number: ______________

Name of Owner(s): ______________________________

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

VII. Certification

"For the purposes of establishing eligibility to receive direct or indirect payment for services rendered to recipients of the Florida Medicaid Program, I understand that, under Section 409.920(2)(f), Florida Statutes, the filing of materially incomplete or false information with this enrollment request is a third degree felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete. Furthermore, I agree to abide by the provisions of this provider agreement effective from the date that the services or goods were provided, pursuant to Section 409.907(11), Florida Statutes.

I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information on this application, including but not limited to, a change of address, group affiliation, ownership, officers, directors, tax identification number, or EFT bank account."

____ _______________________

Signature of Provider or Authorized Agent/Registered Agent Date

____ _______________________

Name of Provider or Authorized Agent/Registered Agent Title
(Please Type or Print Legibly)

- **Keep a copy of the Enrollment Application and all required documentation for your files.**
- **Mail this application and all required documentation to the appropriate office as indicated on the following page.**
- **Note: See the "Guide for Completing a Medicaid Provider Enrollment Application", the web site listed at the bottom of this page, or contact the fiscal agent at 1-800-289-7799, Option 4, for a complete list of required documentation. If you have any questions, please call the fiscal agent at the number above.**

(Office use only - do not write below this line)

APPROVAL:

_______________________ _______________________ _______________________

Signature Print Name Approval Date

Comments:

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

Mail this application and all required documentation to the appropriate office as indicated below:

If you are enrolling as…	Specialty Code	Applications are sent to…
Early Steps Provider, or Children's Medical Services (CMS) Targeted Case Manager, or Case Mgt Agency	N/A	CMS District Office (See Appendix J of the instruction guide for the office near you.)
Adult Cystic Fibrosis Waiver	CF	Department of Health Attention: BSCIP/Adult CF 4052 Bald Cypress Way Tallahassee, FL 32399-1701
Aged/Disabled Adults Waiver	95	Local Area Agency on Aging (See Appendix H of the instruction guide for the office near you.)
Assisted Living for the Elderly Waiver	89	Local Area Agency on Aging (See Appendix H of the instruction guide for the office near you.)
Channeling Waiver	97	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Family and Supported Living Waiver	98	Local Agency for Persons with Disabilities (See Appendix I of the instruction guide for the office near you.)
Consumer Directed Care Waiver	68	Local Agency for Persons with Disabilities Local Area Agency on Aging (See Appendices H and I of the instruction guide for the office near you.)
Developmental Disability Waiver	96	Local Agency for Persons with Disabilities (See Appendix I of the instruction guide for the office near you.)
Model Waiver	94	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Project AIDS Care Waiver	99	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Traumatic Brain Injury & Spinal Cord Injury Waiver	79	Department of Health Attention: BSCIP/Adult CF 4052 Bald Cypress Way Tallahassee, FL 32399-1701
School-based Services Provider (certified match programs)	N/A	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive Mail Stop 20 Tallahassee, Florida 32308
Transportation Provider	N/A	Medicaid Area Office (See Appendix G of the instruction guide for the office near you.)

All other provider types	**For Regular Mail:**	For Overnight or Express Delivery:
	EDS	EDS
	Provider Enrollment	Provider Enrollment
	P.O. Box 7070	2671 Executive Center Circle, Suite 100
	Tallahassee, FL 32314-7070	Tallahassee, FL 32301

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.

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Charlie Crist
Governor

Holly Benson
Secretary

2727 Mahan Drive
Tallahassee, FL 32308
www.fdhc.state.fl.us

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