

Idaho Medicaid Ordering/Referring/Prescribing Provider Enrollment Application

Practitioners can apply to enroll for the sole purpose of ordering, referring, or prescribing for Idaho Medicaid participants. These practitioners *do not and will not* send claims to Idaho Medicaid. If the practitioner intends to bill Idaho Medicaid, a complete standard provider enrollment application must be completed online at www.idmedicaid.com.

All fields are required. **The Idaho Medicaid Provider Agreement at the end of this application MUST be filled out.**

1. Provider Specialty	2. Provider Name	3. National Provider Identifier (NPI)	
4. Professional License #	5. Social Security Number	6. Date of Birth	
7. Practice Physical Address		City	State
			Zip Code
Practice Phone Number		Fax Number	E-mail
8. Practice Mailing Address		City	State
			Zip Code
9. Has there ever been disciplinary action against this provider's license by a licensing board in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION			
10. Has the provider ever been sanctioned by Medicare or any state health program? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION			
11. Has the provider been convicted of a criminal offense related to involvement in any program under, Medicare, Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE ATTACH AN EXPLANATION			
Authorized Name of Person Completing This Form		Signature of Person Completing This Form	
E-mail Address of Person Completing This Form		Phone Number of Person Completing This Form	
Practitioner Signature		Date	

Information disclosed by Provider is subject to verification. Any deliberate omission, misrepresentation, or falsification of any information contained in the Enrollment Request form, or contained in any communication supplying information to the Department, may result in a rejection of the application.

Instructions for Completing the Idaho Medicaid
Ordering/Referring/Prescribing
Provider Enrollment Application

Please type or print information.

If extra space is needed to answer any questions, please attach any additional page(s).
An incomplete form may delay the approval of this application.

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1. Refer to attached listing of Idaho Medicaid provider types for the specialty in box 1.
 2. Enter the licensee name in box 2.
 3. Enter the individual National Provider Identifier (NPI) number in box 3.
 4. Enter the professional license or certification number in box 4 and attach a copy of your license or certification documents.
 5. Enter the 9-digit Social Security Number in box 5 for the individual entered in box 2.
 6. Enter the date of birth in box 6 for the individual entered in box 2.
 7. Enter the practice physical location, phone number, and fax number.
 8. Enter practice mailing address only if different from address in box 7.
 9. Check the **Yes** box and attach an explanation if there has ever been disciplinary action against this provider's license by a licensing board in any state. Check **No** if there has not been any disciplinary action.
 10. Check the **Yes** box if Medicare or any State Health program has ever sanctioned the provider and attach an explanation. Check **No** if there have not been sanctions.
 11. Check the **Yes** box if convicted of a criminal offense related to your involvement in any program under Medicare or Medicaid and attach an explanation. Check **No** if there have been no convictions.

Enter the name of the person completing this form, signature, e-mail address, and phone number. Practitioner must sign and date form.

Provider List

The following practitioners are eligible to enroll in Idaho Medicaid solely for the purpose of ordering, prescribing, or referring.

Provider Type
- Advanced Practice Registered Nurses (Nurse Practitioners)
- Dentists
- Optometrists
- Pharmacists
- Physicians
- Physician Assistants
- Podiatrists
- Psychologists

Most practitioners enroll in the Idaho Medicaid program to be reimbursed for the covered services they furnish to Medicaid participants. However, with the implementation of the Affordable Care Act, Medicaid permits certain practitioners to enroll in the Medicaid program for the sole purpose of ordering, referring, prescribing for Medicaid participants. These practitioners *do not and will not send* claims to the Idaho Medicaid program for processing.

For questions relating to this application, please contact DXC Technology Provider Services at
1 (866) 686-4272 or locally at 1 (208) 373-1424.

Return the completed enrollment form and copy of license to:

**DXC Technology
PO Box 70082
Boise, ID 83707
Fax: 1 (877) 517-2041**

**IDAHO DEPARTMENT OF HEALTH AND WELFARE (IDHW)
MEDICAID PROVIDER AGREEMENT**

Name and address of individual or entity applying to provide these items or services:

Current or previous Provider number for this provider type and specialty: _____
(Does not apply if this is an initial application)

As a condition of participation in Medicaid, the Provider agrees as follows:

1. Compliance.

To provide services in accordance with all applicable federal laws, and provisions of statutes, state rules, and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including IDAPA 16.03.09 – “Medicaid Basic Plan Benefits,” IDAPA 16.03.10 – “Medicaid Enhanced Plan Benefits,” IDAPA 16.03.13 – “Consumer Directed Services,” IDAPA 16.03.17 – “Medicare/Medicaid Coordinated Plan Benefits,” and IDAPA 16.03.18 – “Medicaid Cost Sharing,” as amended; the current applicable Medicaid Provider Handbook; any Additional Terms attached hereto and hereby incorporated by reference; and any instructions contained in provider information releases or other program notices.

1.1. To comply with the Health Insurance Portability and Accountability Act (HIPAA), §§ 262 and 264 of Public Law 104-191, 42 USC § 1320d, and federal regulations at 45 CFR Parts 160 and 164. The Provider shall comply with all amendments of HIPAA and federal regulations made during the term of the Contract. The Provider specifically acknowledges its obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations.

1.2. To protect the confidentiality of identifying participant information that is collected, used, or maintained according to IDAPA 16.05.01, “Use and Disclosure of Department Records,” and 42 CFR § 431.300.

1.3. To comply with the False Claims Act (31 USC 3729-3733). Any Provider who either receives or makes annual Medicaid payments of at least five million dollars (\$5,000,000) shall comply with 42 USC § 1396(a)(68). The Provider specifically acknowledges the responsibility regarding employee education about the False Claims Act and State laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.

1.4. To comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.

1.5. To comply with the disclosure of ownership requirements in 42 CFR § Part 455, Subpart B, and 42 CFR § 411.361, when applicable, and to notify the Department thirty (30) days prior to any change of ownership. This Provider Agreement is not transferable.

1.6. To comply with the advance directives requirements of 42 CFR Part 489, Subpart I, and 42 CFR § 417.436(d), when applicable.

2. Provider Information.

To provide true and accurate information on the Enrollment Request form, Enrollment Attachment (if applicable), Disclosure Statement and all supporting documentation. The provider further agrees:

2.1 To furnish to the Department or to the U.S. Health and Human Services, within thirty-five (35) days of the request, full and complete information related to certain business transactions, specifically about:

- (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.

2.2 To notify the Department of any changes to the information contained in the Enrollment Application, including but not limited to its mailing address and service locations, within 30 days of the date of the change. All correspondence sent to the mailing address on file with the State's fiscal agent shall be deemed to have been received by the Provider.

3. Professionalism.

To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally supervised paraprofessionals where their use is authorized. The Provider shall respect the Medicaid participant's right to privacy, dignity, and free choice of provider.

4. Recordkeeping.

To document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h(3), as amended, applicable rules, and this Agreement. Such records shall be maintained for at least five years after the date of services or as required by rule. In compliance with 42 CFR § 1001.1301, IDHW, the Medicaid Fraud Control Unit of the Office of the Idaho Attorney General, the U.S. Department of Health and Human Services, or their agents, shall be given immediate access to, and permitted to review and copy any and all records relied on by the Provider in support of services billed to Medicaid.

5. Accurate Billing.

To certify by the signature of the Provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Department rules, and this Agreement. The provider further agrees:

5.1 To be solely responsible for the accuracy of claims submitted, and shall immediately repay the Department for any items or services the Department or the Provider determines were not properly provided, documented, or claimed.

5.2 To assure that a duplicate claim under another program or provider type is not submitted.

5.3 To bill only for services delivered by individuals who are not on any state or federal exclusion or disbarment list and have the qualifications required for the type of service that is being delivered.

6. Secondary Payer.

To acknowledge that Medicaid is a secondary payer and to seek payment first from other all sources as required by rule, regulation, or statute, before billing Medicaid. The Provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

7. Payment.

To accept Medicaid payment for any item or service as payment in full and to make no additional charge except that specifically allowed by Medicaid. The Provider further agrees:

7.1. To submit requests for prior authorization, if required, before the item or service is provided. The Provider agrees not to bill Medicaid if a required request for prior authorization is not timely submitted.

7.2. Not to bill the participant unless the item or service is not covered by Medicaid, and the participant has agreed to be responsible for payment prior to receiving the item or service.

7.3. That if a third party pays the participant, the participant may be billed for that amount, and Medicaid will not be billed.

7.4. Not to bill Medicaid or the participant if a third party payment is made to the Provider unless the third party payment is less than the amount Medicaid would pay.

8. Service Providers.

To be responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for its employees, subcontractors, or agents. The Provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal tax withholding for its employees. The Provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

9. Officers and Employees Not Liable.

No official, employee, or agent of the State of Idaho shall be in any way personally liable or responsible for any term of this Agreement, whether express or implied, nor for any statement, representation, or warranty made in connection with this Agreement.

10. Duration and Termination of Agreement.

This Agreement shall remain in effect until terminated in writing. In the event of termination, the Department's sole obligation shall be to pay for services provided prior to the effective date of termination. The Department shall not be responsible for any costs or expenditures of the Provider in reliance upon the terms of this Agreement.

10.1. This Agreement may be terminated by either party without cause by giving thirty (30) days' notice in writing to the other party.

10.2. This Agreement shall be terminated if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of the Agreement infeasible or impossible.

10.3. This Agreement shall be terminated immediately if the Provider's license or certification required by law is suspended, not renewed, or is otherwise not in effect at the time service is provided.

10.4. The Department may, in its discretion, terminate this Agreement in writing when the Provider fails to comply with any applicable rule, term, or provision of this Agreement, either immediately or upon such notice as the Department deems appropriate. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, and IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", as amended. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement. Notice of these sections shall in no way imply that they represent an exclusive or exhaustive list of available actions to deal with fraud and abuse.

11. Provider Liability. If the Provider is any type of partnership, corporation or nonprofit entity, the Provider agrees that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5% or greater, are jointly and severally liable for any breach of this Provider Agreement, and that action by the Department against the Provider may result in action against all such individuals in the entity.

12. Additional Terms, if any, are attached.

Information disclosed by Provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Enrollment Request form, Enrollment Attachment (if applicable), and Disclosure Statement, or contained in any communication supplying information to the Department may be punished by law, including but not limited to revocation of the provider number and recovery of payments made.

I have read the foregoing Provider Agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this agreement constitute sufficient grounds for termination of this Agreement and may be grounds for other action as provided by state rule, federal regulation, or statute.

Printed name of individual practitioner or individual authorized to sign on behalf of the Provider:

Position: _____

By my signature, I declare, under penalty of perjury, that I have the legal authority to enter into this Agreement and hereby bind all entities and individuals that comprise the Provider.

Signature

Date