

Update...

All new enrollment applications submitted after December 20, 2010 must be submitted through the provider enrollment web portal.

All providers submitting a new enrollment application after December 20, 2010 must submit their application utilizing the Provider Enrollment Web Portal at <https://enroll.medicaidalaska.com/>. A new provider is defined as one that has never been enrolled in Alaska Medicaid, is enrolling a new Tax ID or Social Security Number, or is enrolling as a different provider type.

All previously submitted paper applications must be completed by December 20, 2010. If there are extenuating circumstances that prevent a provider from enrolling via the new Provider Enrollment Portal, a hardship request may be submitted to Lyla Crane by phone at 907.644.6853 or by email at lyla.crane@acs-inc.com.

Attention...

New providers must enroll online in the Alaska Medical Assistance Program using the Provider Enrollment Portal (PEP).

You are considered a new provider if:

- * You have never been enrolled in the program, or
- * You are enrolling with a different Tax ID, or
- * You are enrolling as a different provider type

New Providers may go directly to **PEP** and complete your enrollment process online.

Computer Based Training (CBT) is also available to assist you.

ALASKA MEDICAL ASSISTANCE PROGRAM

PROVIDER ENROLLMENT FORM



For ACS Use Only
SPIN _____ TRK _____
OIG Verification Date: _____
Approved _____ Denied _____
Approved Enrollment Date: _____
Authorized Signature/Date: _____/_____

**STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES**

A. General Information (Please type or print)

1. Requested Enrollment Begin Date:

2. Under which Provider Type are you enrolling? (See Attachment A at the end of this form. A separate enrollment application is required for each provider type):

<p>3a. Servicing provider's name:</p>	<p>3b. Servicing provider Social Security number:</p>
<p>3c. Servicing location address: (Cannot be P.O. Box)</p> <p>_____</p> <p>(Street) (Physical location of where services are provided)</p> <p>_____</p> <p>(City) (State) (Zip Code+4)</p>	<p>3d. Correspondence Address:</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>(City) (State) (Zip Code+4)</p>
<p>3e. Servicing provider phone #: ()</p> <p>Servicing provider Fax #: ()</p>	<p>3f. Servicing provider email:</p>
<p>4a. Pay-to business legal name (This name must match the business name provided to the IRS. Payments and tax information are made to this name):</p>	<p>4b. Pay-to business tax identification number: (EIN)</p>
<p>4c. DBA ("Doing Business As" business name, if applicable)</p>	<p>4d. Pay-to business phone #: ()</p> <p>Pay-to business Fax #: ()</p>
<p>4e. Pay-to address: (Payments and tax information will be made to this address)</p> <p>_____</p> <p>(Street/P.O. Box)</p>	<p>4f. Pay-to address city, state, and zip</p> <p>_____</p> <p>(City) (State) (Zip Code+4)</p>
<p>5a. Type of Organization (Check appropriate type):</p> <p><input type="checkbox"/> Individual Practice <input type="checkbox"/> Hospital-based Physician</p> <p><input type="checkbox"/> Partnership <input type="checkbox"/> Group Practice <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Corporation <input type="checkbox"/> IHS/Tribal Owned or Leased</p>	<p>5b. Type of Ownership (Check appropriate type):</p> <p><input type="checkbox"/> Public - Federal, State, or Municipal <input type="checkbox"/> Investor Owned</p> <p><input type="checkbox"/> Charitable, Non-profit, or Religious <input type="checkbox"/> Sole Proprietor</p> <p><input type="checkbox"/> Partnership <input type="checkbox"/> Private Corporation <input type="checkbox"/> Other</p>

6. Is this application for an additional location?

Yes (complete #1 in Section B below)

No (skip #1 in Section B below)

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B. Specific Identifying Information

1. *Providers who render, or are responsible for Alaska Medical Assistance services rendered at separate business locations, must enroll and obtain a State Provider Identification Number (SPIN)* for each location. This does not apply when a provider travels to perform services for patients admitted to a hospital, or residing in a long term care facility, assisted living home, or home residence. (If you are one of the following provider types, you do not need to complete this section Community Mental Health Clinic, Substance Abuse Rehabilitation Treatment Center, Federally Qualified Health Care Center, and licensed facility as defined in AS 47.07.900.)*

I am currently enrolled with Alaska Medical Assistance with the following State Provider Identification Number(s)

Provide the NPI(s) and related taxonomy code(s) that correspond with the provider type specified in Section A, Question 2, on page 1 of this form.

2a. Provider NPI/Subpart NPI*	2a. Provider NPI/Subpart NPI*	2a. Provider NPI/Subpart NPI*
2b. Taxonomy Code(s) Associated with the above NPI*	2b. Taxonomy Code(s) Associated with the above NPI*	2b. Taxonomy Code(s) Associated with the above NPI*
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

2c. Medicare Provider Number(s):
(Attach copy of Medicare Letter assigning your number(s))

2d. NCPDP Number: (Only for Pharmacies and Dispensing Providers, required for POS (Point of Sale))

2e. Drug Enforcement Agency Number (DEA#), if applicable:

3a. If you are a physician, are you board certified or board eligible for certification in a specialty?

Yes No If so, state specialty below:

3b. Are you an intern or resident-in-training?

Yes No

3c. If you are an Advanced Nurse Practitioner, what is your area of specialty?

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C. Group Association

(Groups: List the individual State Provider Identification Number for all members of this group. Attach list if necessary)

(Individuals: List the State Provider Identification Number of all groups, clinics, or agencies with whom you are associated)

Provide State Provider Identification Number

State Provider ID # _____

State Provider ID # _____

State Provider ID # _____

State Provider ID # _____

Provide State Provider Identification Number

State Provider ID # _____

State Provider ID # _____

State Provider ID # _____

State Provider ID # _____

D. Facilities Only (Hospitals and Long Term Care Facilities)

1. *Number of certified beds:*

Acute Care _____ SNF _____ ICF _____

ICF/MR _____ Swing Beds _____

Administrative Wait Beds _____

2. *Fiscal year end date (month/year):*

_____ / _____

E. Disciplinary/Legal Action Information (limitations, restrictions, sanctions)

1. *Have you or any of your employees, contract employees, or any person with ownership or a controlling interest, ever been sanctioned by the Office of Inspector General (OIG), Medicare, Medicaid, or other federal programs?*

Yes No If yes, attach explanation

2. *Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license, certification, or permit?*

Yes No If yes, attach explanation

3. *Has any person who has ownership of, or a controlling interest in, the provider's practice or business entity, or who is an agent, managing employee, contract employee, or employee of the provider's practice or business entity, ever been convicted of a criminal offense related to Alaska's Medical Assistance programs, the Medicaid program in another state or territory, the Medicare program, or any other federally funded health or social service program? [42 CFR 455.106]*

Yes No If yes, please provide the following:

1) *Name of the individual(s)* _____

2) *Type of conviction* _____

3) *Date of conviction, and* _____

4) *Place of conviction (city, state)* _____

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PROVIDER ENROLLMENT FORM

F. Electronic Billing Information

1. Do you plan to bill Alaska Medical Assistance using electronic media?

Yes No

2. If you intend to submit claims electronically, will you be submitting claims that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)? (see Section I of this form)

Yes No

G. Clinical Laboratory Services

To be in compliance with the Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all clinical laboratory testing sites must have a CLIA Certificate of Waiver or Certificate of Registration to legally perform clinical laboratory services rendered on or after September 1, 1992.

Do you perform clinical laboratory services? Yes No

If "yes," please attach a copy of the CLIA Certificate of Waiver or Certificate of Registration.

H. Out-of-State Providers Only

Are you enrolled in the Medicaid program in the state in which you practice? Yes No

If yes: State-assigned Medicaid Provider ID Number (if applicable) _____

Enrollment Date (Month/Year) _____ / _____

Telephone Number of Medicaid Agency: (____) _____

Fiscal Agent: Telephone Number: (____) _____

Name: _____

Address: _____

(Street/P.O. Box)

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

ALASKA MEDICAL ASSISTANCE PROGRAM



PROVIDER ENROLLMENT FORM

I. Provider Agreement, continued THIS IS TO CERTIFY THAT THIS PROVIDER AGREES:

3. To comply with policies and procedures in the applicable Alaska Medical Assistance Program Provider Billing Manual(s).

To not bill or require a prepayment by recipients presenting proper identification of eligibility for Medicaid/Denali KidCare and to accept as payment in full the amounts paid in accordance with Alaska statutes, regulations, policy, and program rules; and make no additional charge to the recipient, any member of his or her family, or any other source for supplementation. This provision does not apply for any service or item not covered by Alaska's Medical Assistance programs. For long-term care services under Medicaid/Denali KidCare, the recipient may be assigned a liability for payment of a portion of the cost of care furnished by the facility. For other services requiring recipient cost sharing, the provider shall collect from the recipient the amount of cost sharing in compliance with the provisions of 7 AAC 145.005, 7 AAC 105.610, and 7 AAC 47.220.

If I accept Chronic and Acute Medical Assistance (CAMA) recipients, I agree to not bill or require a prepayment by recipients presenting proper identification of eligibility for CAMA and to accept as payment in full the amounts paid in accordance with Alaska statutes, regulations, policy, and program rules; and make no additional charge to the recipient, any member of his or her family, or any other source for supplementation. This provision does not apply for any service or item not covered by the CAMA program. For other services requiring recipient cost sharing, the provider shall collect from the recipient the amount of cost sharing in compliance with the provisions of 7 AAC 145.005, 7 AAC 105.610, and 7 AAC 47.220.

To bill any third-party resource, in accordance with state and federal rules, regulations, policies, and procedures. Third-party-resources include, but are not limited to, the following categories:

- Private hospital and medical insurance (to include prepaid health plans);
- Disability compensation insurance;
- Worker's compensation (industrial accident);
- CHAMPUS;
- Veterans Administration (VA) benefits;
- Medicare;
- Railroad retirement;
- Estates or probate of deceased Medical Assistance recipients or responsible persons;
- Absent parents (Child Support Enforcement IV-D Program);
- Liable individuals or entities;
- Accidental injury insurance;
- School injury insurance; and
- Other applicable payers.

That the fees or charges for services or items furnished to recipients of Alaska's Medical Assistance programs will not exceed the fees or charges for comparable services or items furnished to individuals not covered under Alaska's Medical Assistance programs. A provider must bill Alaska Medical Assistance the provider's lowest charge (except for Medicare) that is advertised, quoted, posted, or billed for that same procedure and unit of service* and provided on the same day, regardless of the source or method of payment, including any discounted price offered to any other purchaser of services. The provider's lowest charge does not include: (A) any single contract that contains a discounted rate for a service or group of services and the contract does not exceed 20 percent of a provider's annual gross income; (B) a reduced rate for a service or group of services the provider offers to the provider's employees as part of an employee benefit package; or (C) a contract with a federal or state government agency. 7 AAC 145.005 – 7 AAC 145.005 – 7 AAC 145.025.

*Note: If a provider establishes in writing a sliding fee scale based upon income for families and individuals with income equal to or less than 250 percent of the federal poverty level for Alaska, Alaska Medical Assistance will not consider those fees in determining the provider's lowest charge per service.

As the provider or authorized representative, I have received and read this page. _____ / _____
Initials / Date

**ALASKA MEDICAL ASSISTANCE
PROGRAM**



PROVIDER ENROLLMENT FORM

I. Provider Agreement, continued

THIS IS TO CERTIFY THAT THIS PROVIDER AGREES:

To submit billings for services or items furnished within 12 months after the date of service. The 12-month timely filing limit applies to all claims, including those that must be filed with a third-party carrier. Proof of payment or denial of a third-party claim (Explanation of Benefits) will accompany all billings for recipients with third-party insurance. 7 AAC 145.005 and 7 AAC 160.200.

4. To comply with review and audit regulations. 7 AAC 160.100 - 7 AAC 160.130

To keep financial, clinical, and other records necessary to support the care and services for which payment is requested and to fully disclose the extent of services or items furnished to recipients under Alaska's Medical Assistance programs and any information regarding payments claimed for those services or items. On request, the records and information will be made available to the Alaska Department of Health and Social Services or its authorized representatives to include the federal grantor agency (Department of Health and Human Services), the Comptroller General of the United States, the Alaska Medicaid Provider Fraud Control Unit, or any of their fully authorized representatives.

To provide the Alaska Department of Health and Social Services with financial reports, audited or certified cost statements, and substantiated data necessary to establish a basis for reimbursement under Alaska's Medical Assistance programs pursuant to 7 AAC 150 and applicable federal statutes and regulations.

To comply with regulations relating to recoupment and recovery of overpayments. 7 AAC 105.260.

As the provider or authorized representative, I have received and read this page.

_____/_____
Initials / Date

ALASKA MEDICAL ASSISTANCE PROGRAM



PROVIDER ENROLLMENT FORM

J. Original Signature Required (No photocopies or facsimile signatures will be accepted.)

I understand that I am fully responsible for all health care services provided by myself, my employees and contractors. I further certify that the qualifications and credentials of persons providing and billing for health care services through my practice/business are appropriate and in accordance with Occupational Licensing, Medical Assistance regulations, statutes, and program rules.

I certify that this practice/business is in compliance with all federal and state laws, policies, and rules, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate the Agreement by providing the other party with 30 days advanced notice of intent to terminate. The Alaska Department of Health and Social Services may immediately terminate the Agreement for cause if the individual provider or the group/entity is excluded from the Medicare or Medicaid programs for any reason, loses its license or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. The Alaska Department of Health and Social Services may terminate this Agreement without notice if the individual provider or group/entity has not submitted a claim to the Alaska Medical Assistance Program for 18 months.

I attest that I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Immigration and Naturalization Service to work in the United States. By my signature below, I certify that the information contained in this application and its attachments is true, accurate, and complete, and that I understand and agree to the Provider Agreement.

GROUP/ENTITY PROVIDERS ONLY: *I certify that I have authority to enter into contracts and agreements on behalf of the group or entity requesting enrollment with the Alaska Medical Assistance Program.*

Signature of Provider* or Authorized Representative**
(please use blue ink)

Date

Printed or Typed Name of Person Signing this Agreement

Title

Return to: *Affiliated Computer Services, Inc.
Provider Enrollment Unit
P.O. Box 240808
Anchorage, Alaska 99524-0808*

Telephone Number:
*(907) 644-6800
In-state Toll Free Number (800) 770-5650*

** Individuals and sole proprietors must sign the enrollment agreement form.
**An authorized representative is the duly appointed official of any business organized under the laws of the state of Alaska or other state, to operate as a corporation, partnership, LLC, joint venture, or similar organization ("entity"), who has the legal authority to enroll the entity in the Alaska Medical Assistance program, to make changes and/or updates to the enrollment status of the entity, and to commit the entity to the terms and conditions set forth in this enrollment application. The authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, or direct owner of at least 5% or more of the entity seeking enrollment, or must hold a position of similar status.*

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