Medical Staff Services
12211 Plum Orchard Drive, Suite 310
Silver Spring, MD 20904
Phone: (301) 572-1327
Fax: (301) 572-1312

Dear Provider,

Along with credentialing, Medical Staff Services is responsible for enrolling new applicants with Medicaid and Medicare. The following are the signature pages needed for enrollment with Medicare and Medicaid. Please sign but, do not date the documents in blue ink where appropriate and return along with your credentialing paperwork. Please note, if you forward your credentialing paperwork via e-mail, please send the attached signature pages via regular mail.

If you have provider numbers for any of the following payors: District of Columbia, Maryland or Virginia Medicaid or Medicare, please indicate those numbers on the bottom of this form. If you currently have provider numbers, you still need to sign the accompanying forms in order for us to add your provider numbers to Children's Hospital's group.

In order to reduce the volume of paperwork we send through regular mail and also to reduce the risk of personal information being lost in transit, we are only forwarding the signature pages of each enrollment application. If you would like a copy of the completed applications or have any questions regarding the accompanying documents, please contact Gloria Ransome at 301-572-1322 or gransome@childrensnational.org.

Payor	**Existing Provider Number**
DC Medicaid	
MD Medicaid	
VA Medicaid	
Medicare	

MEDICARE ENROLLMENT APPLICATION
PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS
CMS-855I

The following are the signature pages for the Medicare initial enrollment application. All practitioners should sign these pages, even those who currently have Medicare provider numbers. The signature pages are duplicated so we have a second original signature on file in the event Medicare asks for additional documentation to complete your application.

Medical Staff Services will submit all the necessary supporting documents for your Medicare application. There is no need to submit any documentation in regards to Section 17 of the signature page.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

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☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

MEDICARE ENROLLMENT APPLICATION
REASSIGNMENT OF MEDICARE BENEFITS
CMS-855R

The following are the signature pages for the Medicare reassignment of benefits application. All practitioners should sign these pages, even those who do not currently have Medicare provider numbers. The signature pages are duplicated so we have a second original signature on file in the event Medicare asks us submit any additional supporting documents for you application.

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

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I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services
Physician
VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

The following are the signature pages for enrollment with Virginia Medicaid. Since Virginia Medicaid does not enroll physician assistants, all providers except physician assistants should sign the following two pages.

SECTION IV: REASSIGNMENT OF BENEFITS (ROB) **if you belong to additional Group Practices under same TIN please make sure to list additional Group Practices in question 33.**

The completion of this section is required for individuals whom are participating in a Group Practice

34. Group Practice Legal Business Name: Children's Hospital

35. Group Practice Taxpayer Identification Number: 53-0196580

36. Group Practice (Organization Type 2) National Provider Identifier: 1780800128

37. I certify that this Reassignment of Benefits Statement authorizes the business entity identified in questions #34 through #36 to receive Virginia Medicaid payments on my behalf.

    Individual Provider Signature _____ Date _____

    Printed Name _____

38. I certify as the Authorized Administrator for Group Practice(s) that I have validated information in questions #34 through #36 that it is true, accurate, and complete to the best of his or her knowledge, and that the business entity (employer, group, or health care delivery system) requesting to receive payment is legally eligible to receive reassigned benefits per all applicable federal and state laws.

    Administrator Signature James P. Harris Date _____

    Printed Name James P. Harris

39. REMARKS: Please limit to 500 characters.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
Medical Assistance Program

Participation Agreement

This is to certify:

Provider Name _____

NPI _____

On this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
11. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For ACS' use only

Director, Division of Program Operations Date

Original Signature of Provider Date

DEPARTMENT OF HEALTH CARE FINANCE
DISTRICT OF COLUMBIA MEDICAID

The following are the signature pages for enrollment for District of Columbia Medicaid. Please sign all pages and complete the NPI and taxonomy information on the third page. Please make sure your taxonomy code matches the taxonomy code listed on the NPI website. You can update your NPI at https://nppes.cms.hhs.gov/NPPES.

Please note, the District of Columbia does not enroll Psychologists or Physician Assistants

SECTION XXV AUTHORIZATION TO RELEASE INFORMATION AND AFFIRMATION

I authorize the DC Department of Health Care Finance and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release the carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the carrier.

Applicant Signature _____ Date _____

Applicant's Printed Name _____ Telephone 301·572·1327

P.O. Box 37215 Balt., MD 21297
Mailing Address

X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider attains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I/We agree that the receipt by the D.C. Medicaid program of the first and each succeeding claim for payment from me/us will be the Medicaid program's understanding of my/our declaration that the provisions of this Agreement and supplemental providers manuals and instructions have been understood and complied with:

Provider's Signature _____ Date _____

Children's Hospital

Corporate Name of the Group, Institute, Medical Facility, Firm or Government
(i.e., the Provider Entity)

111 Michigan Ave. NW Wash, DC — Address

301.572.1327 — Phone Number

Signature of individuals responsible to enforce compliance with these conditions

Chief Executive Officer (if applicable) _____ Date _____

Chief Medical Officer (if applicable) _____ Date _____

Principal Corporate Officer (if applicable) _____ Date _____

Accepted by:

Provider Enrollment
Health Care Operations Administration
Department of Health Care Finance

Date _____

For Official Use Only

D.C. Medicaid Provider Number Assigned: _____

DHCF

Government of the District of Columbia
Department of Health Care Finance

Required Application Supplement for NPI

The National Provider Identifier (NPI) final rule, Federal Register 45CFR Part 162, was published on January 23, 2004 by the Department of Health Care Finance (DHCF) as part of the Health Insurance Portability and Accountability Act (HIPAA). The rule established the NPI as the standard unique identifier for health care providers to be used in HIPAA-covered transactions. The rule requires covered health care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

All DC Medicaid healthcare providers must provide DHCF with their NPI information. Please complete the below information and return with your Medicaid Enrollment Application. If you do not have an NPI yet, you may obtain one at https://nppes.cms.hhs.gov/NPPES/Welcome.do. If you do not meet the definition of 'healthcare provider' as defined under HIPAA, this form is not required.

If you are a healthcare provider please provide your NPI that was issued by National Plan & Provider Enumeration System (NPPES) in the space below. Please also provide your taxonomy code that is currently on file with NPPES.

NPI

Taxonomy Code

									X

If this application is for an organization, please supply additional NPIs and taxonomy codes on a separate sheet.

I certify this information to be true and accurate.

Provider Signature or Authorized Representative _____ *Printed Name* _____ *Date* _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION

Attached are the signature pages for Maryland Medicaid enrollment. Please sign both pages.

Please note: Maryland Medicaid does not enroll Physician Assistants

11) MEDICAID INFORMATION

Name: _____ Medicaid Number: _____
State: _____

Name: _____ Medicaid Number: _____
State: _____

Name: _____ Medicaid Number: _____
State: _____

12)AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

Date: _____

Type or Print Name of Practitioner, Administrator or
Authorized Professional Responsible for the Quality of Patient Care: _____

Signature of Practitioner, Administrator or
Authorized Professional Responsible for the Quality of Patient Care: _____

Signature of Owner (in the case of a Pharmacy): _____

Please Return Completed Application to: Systems and Operations Administration,
Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

Provider Signature Date	Department Authorization Date
Provider Name (Typed) Date	Assistant Attorney General Date

P.O. Box 37215 BAH.
Provider Signature Address (Typed)