Return this completed enrollment packet to:

EDS Provider Enrollment
PO Box 23
Boise, ID 83707

Phone: 208-383-4310 Toll-free: 800-685-3757
Fax: 208-395-2198

Do not write here

Enrollment Tracking #

Sanction DUPL New ReEn
EDS: Entered: Effective:
Provider #
Approved:____ Eff Date_____
Type **013** Specialty **131** **0** Ind PPI **A**
Staff Roster WkComp Liability Exempt
Pend Email Software

Idaho Medicaid Provider Enrollment Packet
Psychosocial Rehabilitative Services

Welcome to the Idaho Medicaid Program. This enrollment packet has been prepared for use by Psychosocial Rehabilitative Service providers.

This packet is divided into three parts: 1. Psychosocial Rehabilitative Service Provider Application, 2. Additional Documentation (these forms are included in this packet) and, 3. Attachments (the provider must include copies).

To complete the application process, you will need the following documents. Except for the attachments, all of these documents are included in this enrollment packet. See the instructions in Part 3 for information on attachments.

_____ **Psychosocial Rehabilitative Service Provider Application**(required)

_____ **Medicaid Provider Agreement** (required)

_____ **Disclosure of Ownership and Control Interest Statement** (required)

_____ **Signature on File Form** (optional)

_____ **Authorization for Electronic Funds Transfer Form** (optional)

_____ **Electronic Claims Submission Form** (optional)

_____ **Attachments** (listed in instructions for Part 3)

_____ **W-9 Form** (required)

Before you begin filling out this enrollment packet, first complete the **W-9 Form** that is included at the end of this packet. This is a four-page form that includes directions for completion. It must be signed and dated by the provider. You will use the name, address, and tax identification number entered on the W-9 to complete this application. The name on the W-9 is the name under which you report to the IRS. It is same name used for the 'Pay to' address on page 2 of the application. It must be signed and dated by an authorized representative of the provider. This form is **required**.

Once you have assembled and completed all of the required materials, take a moment to check off each of the pieces listed above. Incomplete applications are returned to the provider. Then, take a second look to be sure that you have remembered to **date and sign** all forms.

Make a copy of this enrollment packet for your records. Send the original to the address at the top of this page. If you have questions about the status of your application, contact the regional program office shown at the top of this page.

NOTE: Do **not** include claims with this enrollment packet. They will be returned.

All forms must be completed in black ink.

Part 1: Psychosocial Rehabilitative Services Provider Application

1. **Provider name and service location:** This is the name and address that the provider will use to submit claims. This name is also entered on the Provider Agreement in Part 2 of this enrollment packet. The address is the physical address of the individual or business. While you may include a post office box, you **must** use a street address. If you have additional service locations, you must submit a separate application packet for each service location.

Name _____

Street Address _____

P.O. Box _____

City _____State _____ Zip _____

Phone (____)_____Email _____

The Department requires a description of the physical location of the Psychosocial Rehabilitation Agency. The following is a list of **requirements** for Psychosocial Rehabilitation physical location. Check only those applicable for the facility described.

- ☐ The facility is structurally sound, maintained, and equipped to assure the safety of the client and staff.
- ☐ The facility is accessible to persons with physical disabilities.
- ☐ There are restroom facilities.
- ☐ The facility's restrooms are accessible to persons with physical disabilities.
- ☐ There is private office space for individual therapy.
- ☐ The facility meets local fire and safety standards.
- ☐ There is adequate space for group therapy.
- ☐ A telephone is available for use by staff and clients in the event of emergency.
- ☐ The facility has ample parking.
- ☐ Clinical records for each participant served at this location are stored at this location.

	YES	NO
2. **Medicaid participation:** have you been an Idaho Medicaid provider at any time in the past?		
3. **Federal Employer Identification Number (FEIN):** Mental Health facilities may use either their SSN or a FEIN. Whichever number is used, it must match the number on the W-9 form.	_____	
4. **Social Security Number:** Mental Health facilities may use either their SSN or FEIN as a tax identification number. Whichever number is used, it must match the number on the W-9 form.	_____	
5. **Medicare number:** providers enrolled with Medicare may enter their Medicare number. This field is optional .	_____	

6. Name, address, telephone, and email: providers may have different addresses and telephone numbers for different purposes. The Pay-to name and address may be the same as the Service Location name and address used on page 1.

Pay-to (required) PRAD01

This is the name that will appear on your check and is reported to the IRS. It must match the name entered on the W-9 form. Checks and remittance advice will be mailed to this address. This is a required field.

Name _____

Street address _____

P.O. Box _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Mail-to Address (optional) PRAD02

This is the name and address where correspondence is mailed, including newsletters and provider handbooks. The Pay-to name and address will be used if the Mail-to address is left blank. This is an optional field.

Name _____

Street address _____

P.O. Box _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Billing service address (optional) PRAD03

This is the name and address that is used if a billing service handles your claims. This is an optional field.

Name _____

Street address _____

P.O. Box _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Contact Address (optional) PRAD13

This is the name and address used for the specific person to be contacted for questions about claims if it is different from the provider. This is an optional field.

Name _____

Street address _____

P.O. Box _____

City _____ State _____ Zip _____

Phone ( ) _____

Email _____

Staff Affiliation Roster – Psychosocial Rehabilitative Services

This roster is **required** for Psychosocial Rehabilitative Services providers. Please indicate the name and credential for each individual providing Medicaid services. Do **not** list individuals who will not be furnishing Medicaid services.

Providers must furnish documentation of appropriate licensure, certification, or degree for each individual providing Medicaid services. The effective dates for all credentials must cover the dates of service in the Idaho Medicaid program. Only staff members with current credentials may provide Medicaid services. Agencies must notify the regional DHW program of all additions and deletions of individuals providing services.

If more space is needed, copy this page and complete the listing.

Staff Person Name	Credentials	Effective Date

Part 2 – Additional Documentation

Included in this enrollment packet are six additional documents. To complete this application you must:

A. Complete the four-page **W-9 Form** found at the back of this packet. Follow the instructions on the form. Be sure that the name is the same as listed for the 'Pay to" address on page 2 of the application and that you date and sign the form. It is the name under which you report to the IRS. This form is **required**.

B. Read, sign, and date the **Medicaid Provider Agreement.** At the top of the form, enter the same name for the provider as you entered for the Provider Name and Service Location on page 2 of the application. An authorized agent must sign and date this agreement. This form is **required**.

C. When submitting paper claims, providers must sign every claim form or complete a signature-on-file form. **If** you wish to submit claims without a handwritten signature, complete the **Signature on File** form. This form allows submission of paper claims without a handwritten signature by using a stamp or the notation, "Signature on file". This form is **optional**.

Indicate the exact notation that will be used on paper claim forms in the provider signature field. This can be the name of an individual (i.e.,*"Florence Nightingale, RN"*), an agency (i.e., *"Idaho's Best Agency"*), or *"signature on file".* Once the signature on file form is received by EDS:

- no other notation will be accepted as a valid signature on claims
- the provider accepts responsibility for all claims submitted with the notation from the signature-on-file form

D. Complete the **Authorization of Electronic Funds Transfer** form **if** you wish to have your payments automatically deposited to your banking account. This form is **optional**.

E. Complete the **Electronic Claims Submission Certification and Authorization** form **if** you wish to bill electronically. This form is **optional**.

F. Complete, sign, and date the **Disclosure of Ownership and Control Interest** form. This form is **required**.

IDAHO DEPARTMENT OF HEALTH AND WELFARE
MEDICAID PROVIDER AGREEMENT

_____
Name and Address of individual or entity applying to provide 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, Provider agrees as follows:

1. Compliance. To provide services in accordance with all applicable provisions of statutes, rules and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including IDAPA 16.03.09 and 16.03.10, 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. The Provider specifically agrees that it is required to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 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.

2. Contact. Providers must advise the Department of its current address or change in ownership. The address must include a physical street address. If a P.O. Box is used, the owner's home address and phone number must be included. All correspondence shall be sent to the mailing address on file with the State's fiscal agent and 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.

4. Fairness. 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.

5. 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 56-209(h)(2), the applicable rules and this agreement. Such records shall be maintained in hard copy for at least five (5) years after the date of services or as required by rule. Upon reasonable request, the Department, the U.S. Department of Health and Human Services or their agencies, 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. The term "immediate access" shall mean access to the records at the time the written request is presented to the provider.

6. 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 shall 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. The provider must assure that they are not submitting a duplicate claim under another program or provider type.

7. Secondary Payor. The Provider acknowledges that Medicaid is a secondary payer and agrees to first seek payment from other sources as required by rule, regulation, or statute.

8. Full Payment. Providers agree to accept Medicaid payment for any item or service as payment in full and agrees to make no additional charge except that specifically allowed by Medicaid. The provider further agrees:

- If required, to submit requests for prior authorization before the item or service is provided. The provider agrees not to bill Medicaid or the client if a required request for prior authorization is not timely submitted;

- Not to bill the client unless the item or service is not covered or approved for payment by Medicaid, and the client has agreed to be responsible for payment prior to receiving the item or service. Medicaid may recoup from the Provider up to three (3) times any amount the Provider charges a Medicaid client in violation of this provision;

- If a third party pays the client, the client may be billed for that amount, and Medicaid will not be billed. The Provider agrees not to bill Medicaid or the client if a third party payment is made to the Provider unless the third party payment is less than the amount Medicaid would pay. The Provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

9. Service Providers. The Provider acknowledges it is responsible for the recruitment, 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 withholdings 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.

10. Ownership. To comply with the disclosure of ownership requirements in 42 CFR § Part 455, Subpart B, and 42 CFR § 411.261, when applicable, and to notify the Department thirty (30) days prior to any change of ownership. This Provider Agreement is not transferable.

11. Advance Directives. To comply with the advance directives requirement of 42 CFR Part 489, Subpart I, and 42 CFR § 417.436(d), when applicable.

12. Confidentiality. To protect the confidentiality of identifying information that is collected, used or maintained about a client. Confidential information shall only be released with appropriate written authorization of the client, according IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR section 431.300.

13. Officers And Employees Not Liable. In no way shall any official, employee, or agent of the State of Idaho be in any way personally liable or responsible for any term of this agreement, whether expressed or implied, nor for any statement, representation or warranty made in connection with this agreement.

14. Duration And Termination Of Agreement. This agreement shall remain in effect until terminated in writing. In the event of termination by the Department, 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.

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

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

14.3. 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.

14.4. 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, in its sole discretion, deems appropriate. Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code Sections 56-227, 56-227A, 56-227B, and 56-209(h) and IDAPA 16.03.09.200-.224, 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 action to deal with fraud and abuse.

15. Additional terms – as provided in Appendix A, attached.

I have read the foregoing agreement, understand it and agree to abide by its terms and conditions. I also agree to abide by the same terms and conditions with respect to any non-Medicaid services that are payable and authorized by the Department. 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 rule, regulation or statute.

Printed name of individual practitioner, or individual authorized to sign for Provider:

_____

Position: _____

By my signature, I affirm that I am authorized to enter into this agreement.

_____ _____

Signature Date

APPENDIX A

MEDICAID PROVIDER AGREEMENT ADDITIONAL TERMS – Mental Health Services

A. Purpose.

The following terms are an extension of the Medicaid Provider Agreement of _____ _____ (*Provider name and number*), and are hereby attached to, incorporated in and are made part of that Agreement.

A-1. Service Designations

The Provider shall provide the following services to eligible participants, but only with a finding by a physician (for PSR services-- a physician or physician extender) that the service is medically necessary as defined at IDAPA 16.03.09.003.40*: (check all those that apply)*

Mental Health Clinic Services

	Psychotherapy (ies)
	Partial Care
	Collateral Consultation
	Pharmacological Management
	Nursing Services
	Occupational Therapy Evaluation
	Psychological Testing

Psychosocial Rehabilitation Services

	Individual Psychosocial Rehabilitation
	Group Psychosocial Rehabilitation
	Psychotherapy (ies)
	Collateral Consultation
	Pharmacological Management
	Nursing Services
	Occupational Therapy
	Psychological Testing

A-2. Minimum Staffing Requirements

The Provider shall employ at all times a minimum of two employees, as described in the appropriate section of IDAPA 16.03.09.465.01(4/6/05), for the provision of mental health services. The Provider may use sub-contractors in addition to the minimum two employees.

A-3. Policies and Procedures.

The Provider shall develop policies and procedures for its agency specific to each Medicaid benefit it provides, and explain the expectations of Provider employees with respect to the delivery of each benefit. The Provider is responsible for ensuring its staff is trained in the Agency's policies and procedures. The Provider shall submit documentation to the Department or its designee of staff training in such policies and procedures upon request.

B. Standards of Conduct.

The Provider shall adhere to published mission, vision and code of ethics. The Provider, its employees, and subcontractors shall not have any conflict of interest, direct or indirect, that would interfere with their performance under this Agreement. Provider must not charge, solicit, accept or receive or offer any amount in the form of a gift, money, donation, or other consideration in exchange for the participant's affiliation with the Provider's agency.

C. Multiple Sites.

The Provider shall ensure that all locations of its Agency meet all requirements as listed in the corresponding section of IDAPA 16.03.09, "Rules Governing Medical Assistance" for each service the Provider provides.

D. Training.

The Provider shall ensure Agency participation in any training required by the Department or its designee. The Department or its designee may charge a reasonable fee for this training. The Provider shall ensure that staff have sufficient training to maintain qualifications and competence to perform all Medicaid reimbursable services offered through its agency. The Provider acknowledges that training is not an –activity reimbursable by the Department.

E. Quality Assurance.

The Provider is responsible for assuring that it provides quality services in compliance with applicable rules. Results of quality assurance reviews conducted by the Department or its designee shall be transmitted to the Provider within twenty-one (21) days after the review is completed. The Provider shall respond within fourteen (14) days after the Provider receives the Department's review. If problems are identified by the Department or its designee, the Provider shall implement a quality improvement plan, which must be approved by the Department or its designee, and report progress on the plan to the Department or its designee upon request. Quality of services shall be evaluated according to but not limited to the following criteria:

E-1. The outcomes for progress (or maintenance, if deemed appropriate) identified on each participant's treatment plan for the service are achieved or are modified due to changes in circumstances, abilities, or a re-assessment to ensure that the scope, amount and duration of services provided are no more than is medically necessary.

E-2. The Provider informs each participant (or legal guardian) of the services to be received, the expected benefits and attendant risks of receiving those services, of the right to refuse services, and alternative forms of services available.

E-3. The Provider, its employees and subcontractors interact with participants in a respectful manner.

E-4. Provider interventions promote participant empowerment and choice. Participants are recognized as primary decision-makers in accessing any and all services, unless an appropriate guardianship has been established by a court or the participant is a minor.

E-5. Services are provided at a time and location that is convenient, acceptable and suitable for the participant and the participant's Provider, and are coordinated, consistent and not a duplication of any other service the participant is receiving.

E-6. The Provider's decision to accept or continue services for a participant is based on the Provider's ability to meet the needs of the participant.

E-7. The Provider schedules services to ensure that the treatment plan for each service is developed and implemented effectively.

E-8. The Provider conducts a quality assurance program consisting of: sufficient training sessions to ensure staff qualifications and competence to provide the services the Agency delivers; quarterly audits of services; participant satisfaction surveys; and annual professional credential and competency review. Provider shall implement a Quality Improvement plan for any deficiencies identified by the Department or its designee.

E-9. The Provider informs the participant or legal guardian about the participant's rights, the availability of protection and advocacy services, and legal assistance.

F. Reports.

The Provider shall:

F-1. Maintain a current list of all participants being served, and all employees, subcontractors or agents, and provide the lists to the Department or its designee upon request. The report shall indicate which staff have received training required by the Department or its designee.

F-2. Immediately notify the Department if any person owning a 5% or greater interest in Provider's business, or any person in a position of control over provider's business, is charged with or convicted of any crime relating to health care fraud, or any crime relating to the abuse, neglect or exploitation of another.

G. Safety.

The Provider shall maintain a safe and secure environment for the population served during all hours of operation including:

G. 1. Exercising sufficient supervision of participants to ensure their safety when services are provided in the community.

G .2. Ensuring participants served by the Agency are not unduly subjected to risk through exposure to such individuals that appear at the Agency for any reason.

G. 3. Ensuring that individual employees of the Agency who transport participants:

- **i.** obtain and maintain all licenses and certifications required by government to operate the types of vehicles used to transport participants;
- **ii.** carry at least the minimum liability insurance required by Idaho law when they transport participants in their own or in Agency vehicles;
- **iii.** adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used.

H. Insurance.

H-1. Commercial General Liability The Provider shall obtain, at the Provider's expense, and keep in effect during the term of this contract, Commercial General Insurance covering bodily injury and property damage. This insurance shall include personal injury liability coverage, blanket contractual liability coverage for the indemnity provided under this contract and products/completed operations liability. The combined single limit per occurrence shall not be less than $1,000,000.00. Each annual aggregate limit shall not be less than $2,000,000.00, when applicable, and will be endorsed to apply separately to each job site or location.

H-2. Professional Liability Insurance. The Provider shall ensure that each of its employees and contractors who bills for Medicaid reimbursable services is covered by Professional Liability Insurance and this coverage shall be kept in effect during the entire term of the contract at their own expense or at the expense of the Provider. The Professional Liability Insurance shall cover any damages caused by an error, omission or any negligent acts. The combined single limit per occurrence shall not be less than $1,000,000.00. The annual aggregate limit shall not be less than $2,000,000.

I. Employees of Department of Health and Welfare.

Department employees are bound by the Department's policies regarding outside employment.

The PROVIDER understands and agrees that violation of any of the terms and conditions of this Additional Terms or the MEDICAID PROVIDER AGREEMENT constitutes sufficient grounds for termination of this agreement and may be grounds for disciplinary action as provided by rules or statute.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Providers must disclose to the State Medicaid Agency the following information:

❶ Enter the legal name of your business: _____

❷ Check (√) the applicable Business Category:
☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Limited Liability Corporation ☐ Government

❸ **A)** List the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more (42 CFR §§ 455.104).
B) List any board members not already listed.
C) Indicate with a check (√) in the applicable column if the person listed has ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any Federal agency or program (42 CFR §§ 455.106).

A & B	**C**		
Name and Address	Sanctioned	Excluded	Convicted

❹ Are any of the persons named above related as spouse, parent, child or sibling to any of the other persons named? ☐ Yes ☐ No If Yes, provide name(s) of person(s) and relationship(s).

_____

❺ Do any of the persons listed in # 3 have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? ☐ Yes ☐ No If Yes, provide the following for each organization.

Organization Legal Business Name	FEIN	Medicaid Provider Number

_____ _____
Provider Signature Date

Signature on File Form

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- The charges submitted for the material furnished and services rendered are correct charges against the State of Idaho pursuant to applicable Department regulations and State law;
- The claim is due;
- I am authorized to sign for the payee;
- Complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services; the Idaho Department of Health and Welfare, and the Medicaid Fraud/SUR Section;
- I accept payment as payment in full subject to adjustment in accordance with the Department regulations;
- All materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from Federal and State funds and that any falsification or concealment of material fact is subject to prosecution under applicable Federal and State laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

The provider or responsible corporate official must sign this certificate statement.

Authorization for Electronic Funds Transfer

Complete all the sections below **if** you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: you must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provider below. (Please, do **not** staple the check.)

Provider Name	
Bank Name	**Bank Phone Number**
Bank Address	
Account Number	
Transaction Routing Number (nine digit) ___ ___ ___ ___ ___ ___ ___ ___ ___	
Type of Account (circle only one) **Checking** **Savings**	

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized Signature _____ Date _____

Name typed or printed: _____

For checking account deposit only,
tape a voided check here.

_____, hereinafter referred to as 'Provider', hereby certifies as follows:
(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the Provider.

The Provider understands that the use of electronic claims submission does in no way relieve the Provider of responsibilities for (a) maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the Provider to Medicaid recipients, and making such records available upon request to the Department of Health and Welfare (DHW) and the United States Department of Health and Human Services; and (b) promptly returning to the Department of Health and Welfare, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The Provider certifies that the claim is due; that the Provider is authorized to sign for the payee; that complete records of these services are being kept in hardcopy form for five (5) years and will be provided upon request. The Provider accepts payment in full for the claims submitted subject to adjustment as authorized by Department regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. The Provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The Provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all Federal and State laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed Provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The Provider understands that any payments made in satisfaction of claims submitted will be derived from Federal and State funds and that any false claims, statements, or documents, or concealment of material fact may be subject to prosecution under applicable Federal and State law.

If the Provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with Federal and State laws pertaining to the Idaho Medicaid Program, as amended.

The Provider understands that the Department reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the Provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The Provider holds EDS harmless and indemnifies EDS against any liability to the Provider, the State of Idaho, or to any Medicaid Provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

DHW shall allow Providers to enter Medicaid claims through the claims entry system developed by the Department's fiscal agent and designated Electronic Claims Submission (ECS), or through the use of entry screens developed by authorized computer vendors, or by magnetic tape or cartridge.

Both EDS and the State of Idaho must approve of any provider **prior** to the submission of electronic claims.

The Provider shall allow the Department access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

Provider Name: _____

Provider Address: _____

City:_____ State: _____ Zip: _____

Phone Number: (_____) _____

Authorized Signature: _____ Date: _____

Name printed or typed _____

SECTION II

(To be completed by Providers using a Billing Service)

The Provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The Provider hereby certifies that _____is authorized to
(Billing Service)
submit electronic claims on Provider's behalf.

The Provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to the Department or its fiscal agent.

Authorized Signature _____ Date _____

Name printed or typed _____

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

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Part 3 – Attachments

Providers are required to include copies of the following documentation unless otherwise noted. It is the provider's responsibility to have valid documentation for all dates of service. Do not send original documents.

NOTE: do **not** send claims with this enrollment packet. They will be returned.

Psychosocial Rehabilitative Services providers are **required** to include a copy of the following:

- General liability insurance policy (unless exempt)
- Workers compensation insurance policy
- Copies of licenses and certification for all staff providing Medicaid services. This includes:
  - Clinical Nurse Specialists
  - Licensed Clinical Professional Counselors (LPCP)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Marriage and Family Therapists
  - Licensed Masters Social Worker (LMSW)
  - Licensed Professional Counselor (LPC)
  - Licensed Social Workers
  - Nurse Practitioners
  - Occupational Therapists
  - Physicians
  - Psychiatric Nurse Practitioners
  - Psychiatrists
  - Psychologist Extenders
  - Psychologists
  - Psychosocial Rehabilitation Specialist*
  - Registered Nurses
  - RN psychiatric nurses certified by a recognized national certification association

Note: A psychosocial rehabilitation specialist shall hold a bachelor's degree from a nationally accredited university or college in a behavioral science education, or medicine. A PSR specialist must have at least twenty-one (21) semester credit hours (or quarter hour equivalent) in human service fields such as psychology, social work, special education, counseling, and psychosocial rehabilitation (documented by a copy of degree and college transcripts).