INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™
CHIP INDIVIDUAL PRACTITIONER ENROLLMENT APPLICATION

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Note: This application is for facilities/agencies wishing to enroll only in the Children's Health Insurance Program (CHIP). Facilities/Agencies seeking enrollment in Pennsylvania's Medical Assistance Program in addition to CHIP should submit the appropriate application for their Provider Type to enroll in Medical Assistance. For further information, please visit

http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Instructions

1. Enter the complete name of the provider.

2. Check the appropriate box for the action(s) requested
   a. Initial Enrollment - This address is not actively enrolled on the provider file and needs added/reactivated
   b. Revalidation - This address is currently active on the provider file and needs updated per ACA regulations
   c. For those individuals who have enrolled previously, indicate the facility/agency's MA ID number (if known).

3. Enter the assigned National Provider Identifier (NPI) Number and taxonomy code(s)
   - Valid DHS taxonomies are listed in the "Provider Type/Provider Specialty to Taxonomy Crosswalk" at http://www.dhs.pa.gov/provider/nationalprovideridentifiernpiinformation/index.htm
   - Attach an additional sheet if there are more than four (4) taxonomies for this location

4. Enter the requested effective date for the action request

5. Enter the provider type number and description (e.g. - Number: 06; Description: Hospice)

6. Enter the Specialty/Sub Specialty - See the requirements document for the provider type
   a. Enter the PRIMARY Specialty Code/Description and Sub-Specialty Code (if applicable) (e.g. - Specialty Code: 060; Description: Hospice; Sub Specialty Code: N/A)
   b. Enter additional Specialty/Description and Sub-Specialty codes (if applicable)

7. Enter the Name and Social Security Number as registered with the IRS
   a. Enter the SSN as assigned by the IRS
   b. Enter the legal name as it is registered with the IRS
   c. **If you are a U.S. citizen, but were not born in the U.S. you must provide a copy of your U.S. resident card or your U.S. issued passport. If you are not a U.S. citizen you must provide a copy of your I-797B, Notice of Action issued by the Department of Homeland Security, U.S. Citizenship and Immigration Services.**

8. Enter your Date of Birth.

9. Enter your Gender.

10. Dental Providers only – If you have an anesthesia permit please answer yes, and attach a copy.

11. Enter your license number, issuing state, issue date, and expiration date.
    A legible copy of your license must be included with the application.

12. Check the appropriate box for the business type of the entity applying for enrollment
    a. Include a legible copy of the corporation papers or business partnership agreement (if applicable)
    b. **If Not-for-Profit, include proof of tax exemption (if applicable)**

13. Enter the physical address of the service location.
    a. The address must be a physical location - **NOT** a post office box - **Please note: All addresses will be geocoded per the US Postal Service (**https://tools.usps.com/go/ZipLookupAction!input.action**)**
    b. The phone/fax numbers must be for the service location
    c. Check the appropriate boxes to denote if this location has been enrolled, credentialed, and/or revalidated by one of the listed entities within the last 5 years.
    d. Check the appropriate boxes to denote if this address should also be used as the Home Office or Mail To.

14. Enter the contact information for issues/questions about **this** application.

15. The Provider Eligibility Program (PEP) item has been pre-filled with the appropriate PEP for CHIP-only providers.

16. Confidential Information Questions
    a. The representative of the provider applying for enrollment must complete ALL confidential Information questions (A-E)
    b. If answering "Yes" to any of the questions, provide a detailed explanation on a separate piece of paper and attach it to the application. Refer to the Confidential Information sheet for the information that must be included in the explanation.

17. Sign the application and print your name, title, and the date (the signature should be that of someone able to represent the provider applying for enrollment) - **Use black ink.**

18. Enter Mail-To/Home Office Information
    a. This page may be used to add a Mail-To and/or Home Office address to the previously listed service location address listed in Question 12.

19. Complete and sign the Provider Agreement

20. Ownership & Control Interest
    a. Section I - This section must be completed by all providers
    b. Section II - This section should be completed by any entity that is formed as a corporation, partnership, estate trust or government entity (regardless of for-profit/non-profit status)
    c. Section III - This section should ONLY be completed by non-profit entities that are not formed as a corporation

When completed, review the "Did You Remember…?" Checklist included with the application.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program identifies a program for which a provider may apply. A provider must be approved in that program to provide services to beneficiaries of that program. Providers should use the following PEP when enrolling in CHIP.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Office of CHIP – (800) 986-5437

This program was created to provide quality health insurance to uninsured children that reside in households with income exceeding the current levels for medical assistance. CHIP is comprised of three components. Depending on a family's Modified Adjusted Gross Income and household size, a child can be enrolled in Free, Low or Full Cost CHIP.

Eligibility:

- Be under 19 years of age
- Be a U.S. citizen or qualified alien
- Be a Pennsylvania resident
- Be uninsured or not eligible for MA

Services:

- Immunizations
- Routine check-ups
- Prescription drugs
- Dental care
- Oral surgery
- Vision and eye care
- Hearing Care
- Maternity care
- Inpatient and outpatient mental health services
- Inpatient hospitalization
- Durable medical equipment
- Inpatient and outpatient Substance use disorder treatment
- Partial hospitalization for mental health services
- Rehabilitation therapies
- Home health care
- Hospice and Palliative services
- Medically necessary orthodontia
- Autism spectrum disorder and related services
- Primary and preventive care
- Specialist care
- Case management services
- Chiropractic care
- Diagnostic services
- Emergency care
- Transplant services
- Orthotics and prostheses
- Outpatient habilitation services
- Skilled nursing services
- Surgical services
- Urgent care
- Women's health services
- Telehealth visits
- Participation in qualifying clinical trials
- Pharmacy services
- Gender transition
- Diabetic care

The PEP identifying providers of CHIP services is:

- **CHPPR** – used for Individuals and Agencies directly providing healthcare services under CHIP

CHIP PROMISe™ PROVIDER ENROLLMENT APPLICATION

1. Enter Name of Provider:

Last Name: _____ First: _____ MI: _____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment

b. ☐ Revalidation

c. ☐ Check here if previously enrolled in Medical Assistance (MA)

Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

d. ☐ Add this provider to an existing provider group. Specify group provider number:

(Must be a 13-digit number to be processed.) ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

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3. National Provider Identifier Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (10 digits)

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

4. Requested Effective Date (yyyy / mm / dd):

_____/ ____/ ___

5. Provider Type Number and Description:

Number: _____

Description: _____

6. Provider Specialty/Sub-Specialty:

Specialty: ___ ___ ___ Description: _____ Sub-Specialty: ___ ___ ___

Specialty: ___ ___ ___ Description: _____ Sub-Specialty: ___ ___ ___

7a. Social Security Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ (9 digits)

If you are a U.S. citizen, but were not born in the U.S. you must provide a copy of your U.S. resident card or your U.S. issued passport. If you are not a U.S. citizen you must provide a copy of your I-797B, Notice of Action issued by the Department of Homeland Security, U.S. Citizenship and Immigration Services.

8. Date of Birth: yyyy/mm/dd
Ex: (2004/07/31)

___ ___ ___ ___ / ___ ___ / ___ ___

9. Gender

Male ☐ Female ☐

10. Dental Providers – Do you have a permit for the administration of anesthesia issued by the PA Department of State?

☐ Yes ☐ No If you answered yes, please attach a copy of your Permit.

11a. License Number: _____ b. Issuing State:_____

c. Initial issue Date: _____ d. Expiration Date: _____

A copy of your license is required for your application to be processed

12a. Drug Enforcement Agency (DEA) Number:_____

b. Initial issue Date: _____ Expiration date_____

c. Check this box if you do not have a DEA certificate number ☐

If you have a DEA number, a copy of your DEA certificate is required for your application to be processed.

13. Service Location Address:

NOTE: A <u>Service Location</u> is defined as a physical street address where a practitioner:

1.) Maintains an office, 2.) Holds office hours/sets appointments and 3.) Renders services.

A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.

Each Service Location must be enrolled separately. Additional Service Locations may be submitted with this application using Attachment 1.

Street: _____ Room/Suite:_____

City: _____ State: ____ Zip: __ __ __ __ __ - __ __ __ __ (9 digits) County: _____

Business Phone: ( ) _____ - _____ Fax Number: ( ) _____ - _____

a. **Has the provider named in Block 1 been screened for this location within the last 5 years by:**

i. Medicare? ☐ Yes ☐ No

ii. Children's Health Insurance Program (CHIP)? ☐ Yes ☐ No

iii. Another state's Children's Health Insurance Program (CHIP)? ☐ Yes (Complete below) ☐ No

iv. Another state's Medicaid program? ☐ Yes (Complete below) ☐ No

Screening State	Screening Contact Phone Number	Screening Contact Email Address

b. **Check all applicable boxes. This service location is also a:** ☐ **Mail-to** ☐ **Home Office**

If Mail-to and/or Home Office are different from above address, refer to question 18.

14a. Contact Name: _____ Title: _____

***This is the contact name and phone number we will use if we have any questions about this application**

14b. Contact Toll-Free Phone:	14c. Contact Fax Number:	14d. Contact E-mail Address:
( )	( )	

15. Provider Eligibility Program (PEP): Refer to PEP descriptions included in the instructions.

CHPPR

16. Have you or anyone in your employ ever:

A. Been terminated, excluded, precluded, suspended, debarred from, or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

☐ Yes ☐ No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

☐ Yes ☐ No

C. Had a controlled drug license withdrawn?

☐ Yes ☐ No

D. Been convicted of a criminal offense related to CHIP, Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

☐ Yes ☐ No

E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☐ No

If answering "Yes" to any of the questions listed above, provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to this application. Include the following information as applicable to the situation:

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g. felony, misdemeanor)

17. This form requires the original signature of the authorized agent or representative of the provider

_____ _____

Title Printed Name

_____ _____

Original Signature Date

18. Mail-To /Home Office Information For The Service Location Entered In 13

NOTE: Do not use this sheet to add service locations.

a. **Address:** Street	Suite/Box	City	State	Zip **(9-digits)**	County

b. This address is a: ☐ Mail-to ☐ Home Office	c. E-mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number: ( )

a. **Address:** Street	Suite/Box	City	State	Zip (**9-digits)**	County

b. This address is a: ☐ Mail-to ☐ Home Office	c. E-mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number: ( )

THIS SPACE INTENTIONALLY LEFT BLANK

Provider Agreement for CHIP Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

_____ (hereinafter the "Provider") sets forth the terms and conditions governing participation in the Children's Health Insurance Program (CHIP). The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the CHIP Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the MCO Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania CHIP Program.
4. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
5. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
    A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and
    B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5–year period ending on the date of the request.
6. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents, its contractor, and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
7. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.
8. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
9. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
10. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania CHIP Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

_____ _____

Provider Original Signature **Date**

_____

Name – Please Type or Print

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of a provider's total operating expenses.

Subcontractor means:

a. An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the CHIP agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under CHIP (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Ownership and Control Interest Disclosure

Note: Ownership and Control Interest information is required in accordance with Federal Regulations at 42 CFR, Part 455.

A. Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the enrolling individual practitioner.

The following individual is a: ☐ **Managing Employee** ☐ **Agent**

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

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

1. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY THIS PAGE TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

B. Please enter the full name and federal tax identification number of all subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more.

a. Name of Subcontractor: _____

Federal Tax ID of Subcontractor: _____

b. Please enter the percentage and ownership type that the enrolling individual practitioner has in the subcontractor.

☐ **Direct:**_____% (Percent of Ownership) ☐ **Indirect:**_____% (Percent of Ownership) _____ (Name of Entity Owned)

****ATTACH SEPARATE SHEET TO ADD ADDITIONAL SUBCONTRACTORS****

30. Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

31. Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

☐ **Yes (Provide details below)** ☐ **No**

Name of Supplier/Subcontractor: _____

Social Security Number or Federal Tax ID: _____ Date of Birth: _____ (Individuals only)

Address: _____ Suite/Apt: _____

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

****ATTACH SEPARATE SHEET TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

Attachment 1

Additional Service Location Address:

NOTE: A Service Location is defined as a physical street address where one or more practitioners:
1.) Maintain an office, 2.) Hold office hours/set appointments, and 3.) Render services.

A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.

Each Service Location must be enrolled separately. To add ADDITIONAL service locations, copy and complete this page as needed for each location you wish to add.

1. Service Location Address:

Street: _____ Room/Suite:_____

City: _____ State: ____ Zip: __ __ __ __ __ - __ __ __ __ (9 digits) County: _____

Business Phone: ( ) _____ - _____ Fax Number: ( ) _____ - _____

a. **Has the provider named in Block 1 been screened for this location within the last 5 years by:**

Medicare?	☐ Yes	☐ No
Children's Health Insurance Program (CHIP)?	☐ Yes	☐ No
Another state's Children's Health Insurance Program (CHIP)?	☐ Yes (Complete below)	☐ No
Another state's Medicaid program?	☐ Yes (Complete below)	☐ No

Screening State	Screening Contact Phone Number	Screening Contact Email Address

b. **Check all applicable boxes. This service location is also a:** ☐ **Mail-to** ☐ **Home Office**

If Mail-to and/or Home Office are different from above address, refer to question 18.

2. Link rendering provider to: ☐ Existing provider group number:

___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Link rendering provider to: ☐ New provider group applicant named:

_____

3. Specialty(s) and Code(s), if applicable:

Specialty: _____

Code: _____

4. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): ___ ___ ___ / ___ ___ ___

5. If the taxonomy(s) for this service location differ from the service location identified on page 6, item 12, please provide the taxonomy(s) for this particular service location:

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

6. Provider Eligibility Program (PEP): Refer to PEP descriptions included in the instructions. **Choose at least 1 PEP.**

a. CHPPR

Provider Enrollment Application Checklist

The following checklist contains the most common reasons Pennsylvania CHIP Program enrollment applications are not accepted due to missing vital information. Please complete this checklist and **submit it with your application**. Incomplete applications will not be processed.

Document will be scanned – Please do NOT staple.

Did you remember to….

- ❑ **USE BLACK INK. (Application must be typed or printed in black ink.)**
- ❑ **Complete all spaces** as required on the application with either your correct information or N/A.
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ Attach a separate sheet listing the additional codes if you have more than 4 taxonomy codes.
- ❑ Indicate ***one*** **primary** provider type, provider specialty and sub-specialty(s), as applicable.
- ❑ If you are not a US Citizen, include a copy of your documentation from Department of Homeland Security that shows proof of authorization to work in the United States.
- ❑ **Include a legible copy** of your:
  - ❑ Professional License

  Also include any other certification, license, or permit that applies, including but not limited to:
  - ❑ DEA Certificate
  - ❑ Dental anesthesia permit (if applicable)
- ❑ Only the **person applying for enrollment** can sign and date the **provider agreement**. Signature stamp not accepted.

When completed, review the "Did You Remember…?" Checklist included with the application.
Return the application and other documentation TO:

DHS Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045
Fax: (717) 265-8284
E-mail: Ra-ProvApp@pa.gov