GOBIERNO DE PUERTO RICO
Administración de Seguros de Salud

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Puerto Rico Medicaid Government Health Plan (GHP) Provider Enrollment Application Guide

This guide has been prepared to assist with the online provider enrollment form available on the ASES website at www.asespr.org. This document is not the provider enrollment form and cannot be submitted to ASES for enrollment purposes.

General Information

1. CMS has recently implemented a separate requirement that all providers furnishing items or services, or ordering, prescribing, referring or certifying eligibility for services for Medicaid patients to be appropriately screened and enrolled with the state. This requirement now extends to all providers participating in the network of a MCO under the Medicaid program as well.

2. This new process does **not** replace the MCO's contracting process. MCOs must still credential and contract with health care providers in order to include them in their provider networks. MCOs must also report certain credentialing information to ASES in order to support the state-specific enrollment process.

3. Please make sure to fill out this provider enrollment application in full. Incomplete applications will delay processing and approval of your application.

4. Sections that must be answered are marked with an asterisk. There are certain sections that are specific to individual providers, group practices and facilities, organizations or suppliers so not all sections must be filled out by all providers. These sections include an explanation that certain fields do not need to be populated in certain cases, or are accompanied by headings such as "if individual provider" or "if group practice."

5. All supplemental instructions are included below in red. All other information appears in the online application.

Provider Information

1. **Provider Enrollment Type: *** ○ Individual Provider
   ○ Group Practice
   ○ Facility, Organization or Supplier

   An "individual provider" means a physician or other health care provider operating as a solo practitioner. An individual provider typically bills under his or her own NPI or billing number.

   A "group practice" means two or more health care providers practicing at a common location and billing under the group practice's billing number.

   The "facility, organization or supplier" provider type includes all other entities (e.g. pharmacies and laboratories), institutions (e.g. hospitals and long-term care facilities), and suppliers (e.g. DMEPOS suppliers or other entities from which goods or services are purchased) billing to Medicaid. If the applicant has a FEIN, then this designation is most appropriate unless the applicant is part of a physician group practice.

2. **If Individual Provider:** Name: _____

   Social Security Number: _____

   Date of Birth: _____

   If Group Practice or Facility, Organization or Supplier: Name: _____

   Federal Employer Identification Number (FEIN): _____

3. **Primary Service Address**: * Street Address: _____

   City: _____

   State: _____

   Zip Code: _____

4. **Mailing Address, if different**: Street Address: _____

   City: _____

   State: _____

   Zip Code: _____

5. **National Provider Identifier (NPI) Number**: * _____

6. **Additional Practice Locations.** If you see patients in more than one practice location, please provide the service address and NPI number, if different, below. There will be space to enter up to three additional practice locations. If you have more than three additional practice locations, attach a list with each service address and NPI number for each additional practice location to the Comments and Attachments section below.

   Additional Practice Locations: Street Address: _____

   City: _____

   State: _____

   Zip Code: _____

   NPI Number: _____

7. **Are you enrolled as a Medicare provider?** * ○ Yes ○ No

   You must be in enrolled and in good standing to be considered an enrolled Medicare provider.

8. **Specialty**. Please enter the appropriate Medicare Specialty Code based on the CMS Provider Taxonomy Crosswalk available at the link here: ___

   Use the hyperlink above to access a list of provider specialty codes used by CMS. Use the two-digit Medicare Specialty Code in the first column of the chart.

9. **Licenses.** Please list all federal and state health care licenses, permits or certifications. If you have more than three types of licenses, permits or certifications, attach a list of the license types and numbers for each additional license, permit or certification to the Comments and Attachments section below.

License Type 1: _____ License Number: _____

License Type 2: _____ License Number: _____

License Type 3: _____ License Number: _____

Please make sure to include any clinical and professional licenses that allow you to perform the health care services you will be providing to Medicaid enrollees, such as any medical or clinical licenses, DEA registrations, pharmacy licenses, CLIA or laboratory licenses, etc. Please do not include any general business registrations, hazardous waste registrations, or other licenses that do not pertain to the provision of health care services. Please list any additional licenses in a separate attachment. You do not need to provide us with copies of your actual licenses.

10. **Contact Information.** Please provide the following information for the appropriate person to contact with questions about your application.

Contact Name: _____

Contact Telephone Number: _____

Contact Fax Number: _____

Contact E-Mail Address: _____

11. **Network Providers.** If you have been contracted with a Managed Care Organization to provide services under the Puerto Rico Medicaid Program, please indicate for which Managed Care Organization you are providing services as a network provider. Please make sure to select all applicable MCOs or PBM.

O First Medical	O Molina Health Care
O MMM	O Triple- S
O MC-21	

Disclosure of Adverse Actions

12. **Disclosure of Adverse Actions.** Please indicate below if you, as an individual provider, or your practice or organization have had or currently have any of the following final adverse actions imposed. If yes, attach a copy of the final adverse action documentation and resolution to the Comments and Attachments section below. Please note that the term "state" includes any U.S. territories, including Puerto Rico.

O Yes O No a. A federal or state felony conviction of any type within the last 10 years.

O Yes O No b. A federal or state misdemeanor conviction related to:

(1) The delivery of any item or service under Medicare or Medicaid.

(2) The abuse or neglect of a patient in connection with the delivery of a health care item or service.

(3) Theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

(4) The interference with or obstruction of any federal or state investigation into any criminal offense in connection with the delivery of a health care item or service.

(5) The unlawful manufacture, distribution, prescribing or dispensing of a controlled substance.

○ Yes ○ No c. Any disciplinary action taken against a health care license or certification held in any state or territory, including but not limited to disciplinary action, nolo contendere, probation, consent order, suspension, revocation or voluntary surrender of a license or certification while a disciplinary proceeding was pending.

○ Yes ○ No d. A denial of enrollment in Medicare, Medicaid or any other federal or state health care program. A denial by a MCO or PBM to enter into a provider network contract is not considered a denial of enrollment by Medicare, Medicaid or other government health care program.

○ Yes ○ No e. A suspension or revocation of billing privileges under Medicare, Medicaid or any other federal or state health care program.

○ Yes ○ No f. Any debarment, suspension or exclusion from participation in a federal or state health care program.

Disclosure of Ownership and Control, Subcontractors and Managing Employee

This section is for facilities, organizations or suppliers only. If individual provider or group practice, you do not need to complete this section. Please skip to next section if you are not a facility, organization or supplier.

13. **Ownership or Control Interest.** List the names of all individuals and entities with an ownership or control interest in the applicant. ***Ownership interest*** means the possession of equity in the capital, stock or profits of the applicant. ***Control interest*** means the management or direction of the operations of the applicant. This includes any individual or entity that:

- Has an ownership interest totaling 5% or more in the applicant.
- Has an indirect ownership interest equal to 5% or more in the applicant.

  For example, if a person owns 10% of the applicant's parent company, and the parent owns 80% of the applicant, then that person has an indirect ownership interest of 8% that must be reported in this application.
- Has a combination of direct and indirect ownership interests equal to 5% or more in the applicant.
- Owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the applicant if that interest equals at least 5% of the value of the property or assets of the applicant.
- Is an officer or director of an applicant, if a corporation, or is a partner of the applicant, if a partnership.

  An officer is a person who is listed as an officer in the applicant's articles of incorporation or by-laws, or is appointed as an officer of the company by the board of directors or other governing body. A director is a member of the applicant's board of directors, board of trustees or other governing body. A director is not necessarily an individual who has the word "director" in his or her job title.

Please complete the information below. You will be given space to enter information for up to five individuals or entities. If you have more than five individuals or entities to disclose, attach a list with the following information for each additional individual or entity to the Comments and Attachments section below.

Ownership or Disclosure Interest Disclosure:

Name: _____

If Individual: Social Security Number: _____

Date of Birth: _____

If Entity: Federal Employer Identification Number (FEIN): _____

Address: Street Address: _____

City: _____

State: _____

Zip Code: _____

Please attach a list every additional business and P.O. Box addresses for this individual or entity to the Comments and Attachments section below.

If individual, is he or she related to any other individual listed in this Section 13 as a spouse, parent, child or sibling? If yes, please provide an explanation of the relationship below. ○ Yes ○ No Explanation of relationship, if applicable:

_____

_____

If any of the individuals you are including in this section are related to each other as a spouse, parent, child or sibling, you must answer yes and describe the relationship, i.e. Person X is the child of Person Y.

Has this individual or entity had or currently have any of the final adverse actions listed in Section 12 imposed? If yes, attach a copy of the final adverse action documentation and resolution to the Comments and Attachments section below. ○ Yes ○ No

You must specify whether any of the individuals or entities have experienced any of the adverse actions listed in the previous Section 12. Please include a description of the circumstances of the adverse action and any related documents that would help explain the action.

Does this individual or entity have an ownership or control interest in any other Medicare or Medicaid provider organization, fiscal agent, managed care organization, Medicare intermediary or carrier, or other entity that furnishes or arranges for the furnishing of health-related services paid by Medicare or Medicaid? If yes, please provide the name of the other organization(s) below. ○ Yes ○ No

Name of other Medicare or Medicaid organization or entity: _____

The same definitions of "ownership or control interest" as explained at the beginning of the section apply here. For example, if Person X owns more than 5% direct or indirect interest in another company that provides health-related services reimbursed by Medicare or Medicaid, you must include the name of that other company for Person X.

14. **Subcontractors.** List the names of all subcontractors in which the applicant has an ownership or control interest. You will be given space to enter information for up to two subcontractors. If more than two subcontractors, attach a list with the name and FEIN for each additional subcontractor to the Comments and Attachments section below.

List any subcontractors that the applicant owns or controls. The same definitions of "ownership or control interest" as explained at the beginning of the section apply here.

Name of Subcontractor: _____

Federal Employer Identification Number (FEIN): _____

Is any individual with ownership or control interest of the subcontractor related to any other individual listed in Section 13 as a spouse, parent, child or sibling? ○ Yes ○ No If yes, please provide an explanation of the relationship below.

Explanation of relationship, if applicable: _____

_____

If any of the individuals who own or control the subcontractor is related as a spouse, parent, child or sibling to one of the individuals you disclosed with an ownership or control interest in the applicant, you must answer yes and describe the relationship, i.e. Person X is the child of Person Y.

15. **Managing Employee.** List the names of any managing employees of the applicant. You must designate at least one. A ***managing employee*** is 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. You will be given space to enter information for up to three managing employees. If you have more than three managing employees to disclose, attach a list with the following information for each additional individual to the Comments and Attachments section below.

    Name of Managing Employee: _____

    Street Address: _____

    City: _____

    State: _____

    Zip Code: _____

    Social Security Number: _____

    Date of Birth: _____

    Has this managing employee had or currently have any of the final adverse actions listed in Section 12 imposed? If yes, attach a copy of the final adverse action documentation and resolution to the Comments and Attachments section below. ○ Yes ○ No

    You must specify whether any of your managing employees have experienced any of the adverse actions listed in the previous Section 12. Please include a description of the circumstances of the adverse action and any related documents that would help explain the action.

Application Fees

Under 42 C.F.R. § 455.460, certain providers must pay an application fee prior to the execution of the following Provider Enrollment Agreement. However, providers already enrolled in Medicare or another state's Title XIX or XXI program, or who have paid the applicable application fee to a Medicare contractor or another state, will not be charged an application fee to enroll as a GHP provider. In addition, individual physicians or non-physician practitioners are also exempt from application fees. Please indicate below if you are eligible for an exemption for these reasons. Otherwise, ASES will separately invoice providers the applicable application fee.

16. **Application Fee.** Are you eligible for an exemption from paying an application fee? ○ Yes ○ No

    The fee applies only to facilities, organizations or suppliers who are not already enrolled in Medicare or another state's Medicaid program, or who have paid an application fee to a Medicare contractor or another state. Individual providers

and group practices are exempt from this fee. The fee is $569. ASES will invoice applicants who must pay the enrollment fee upon receipt of the application.

Comments and Attachments

Please upload any additional materials here: [ ]

Applicants are required to upload documents in order to (1) supplement information in the application where the applicant has run out of fields, e.g. more than 3 practice locations, or more than 5 individuals or entities with ownership or control interest, or (2) provide an explanation for any "yes" responses to the adverse action questions in Section 12. The file capacity is five (5) MB. We do not anticipate that any attachments will exceed this file size. **You can only upload one (1) pdf file, so please make sure to consolidate any separate documents into a single attachment.**

Provider Enrollment Agreement and Signature

This section provides you with the terms and conditions of your provider enrollment with ASES, and not with the MCOs or PBM. You may wish to obtain a copy of the agreement for your reference. ASES will not be mailing separate copies of this agreement in executed form. In order to sign the agreement, please type your first and last name at the bottom. You must have authority to sign on behalf of a group practice, facility, organization or supplier in order to execute this agreement.

This Agreement, effective on the date specified on the signature page of this document, between Administración de Seguros de Salud de Puerto Rico (hereinafter "ASES") and the undersigned Provider (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Puerto Rico Health Insurance Administration Act, and rules and regulations promulgated thereunder to provide physical and/or behavioral health services (hereinafter called "Service" or "Services") to eligible Puerto Rico Government Health Plan ("GHP") recipients (hereinafter called "Recipient(s)"). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

1. **Provider Agrees**:

1.1. To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by ASES relating to the Provider's performance under this Agreement and to hold harmless, indemnify and defend ASES from all negligent or intentionally detrimental acts of the Provider, its agents and employees.

1.2. To provide Services to Recipients without regard to age, sex, race, color, religion, national origin, disability or type of illness or condition. This includes providing Services in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794). To provide Services in accordance with the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 CFR §§ 36.101 through 36.999, inclusive.

1.3. To provide Services in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended and the HITECH Act and related regulations at 45 CFR 160, 162 and 164.

1.4. To obtain and maintain all licenses, permits, certifications, registrations and authority necessary to do business and provide Services under this Agreement. Where applicable, the Provider shall comply with all laws regarding safety, unemployment insurance and workers' compensation. Copies of applicable licensure/certification must be submitted at the time of each license/certification renewal.

1.5. To check the List of Excluded Individuals/Entities on the Office of Inspector General ("OIG") website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors.

1.6. To comply with all protocols set forth by ASES, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of Provider.

1.7. To safeguard all information on Recipients, in accordance with the requirements set forth in 42 CFR 431 subpart F and under Puerto Rico law. To ensure appropriate security, Provider agrees that no processing or storage of Protected Health Information as defined by HIPAA or electronic transactions with ASES will be conducted from outside the territorial limits of the United States.

1.8. To permit unannounced on-site inspections of any and all locations as provided under 42 C.F.R. § 455.432.

1.9. To consent to criminal background checks, including fingerprinting, when required to do so, as provided under 42 C.F.R. § 455.434.

1.10. To submit, within thirty-five (35) days of the date on a request by ASES or its agent, full and complete information regarding (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and (b) any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the five (5) year period ending on the date of the request, as provided under 42 C.F.R. § 455.105.

1.11. To exhaust all Administrative remedies, including the reconsideration and appeal process and the Fair Hearing process set forth under Puerto Rico law, prior to initiating any litigation against ASES.

2. **Reimbursement**.

2.1. Upon enrollment in Medicaid, Provider shall receive payment for all Services properly authorized, timely claimed, and actually and properly rendered by Provider in accordance with federal and state law and the state policies and procedures set forth by ASES. Other claims are not properly payable Medicaid claims.

2.2. The Provider is responsible for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service.

2.3. The Provider agrees to pursue the Recipient's other medical insurance and resources of payment prior to submitting a claim for Services for Medicaid payment. This includes but is not limited to Medicare, private insurance, medical benefits provided by employers and unions, workers' compensation and any other third party insurance.

2.4. The Provider shall accept payment from ASES, through the Provider's contracted Managed Care Organizations (MCOs) or Pharmacy Benefit Manager (PBM), as payment in full on behalf of the Recipient, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in Section 2.3 above or as otherwise provided by law. The Provider shall immediately repay ASES, through the Provider's contracted MCO or PBM, in full for any claims where the Provider received payment from another party after being paid by under Medicaid.

2.5. Upon receipt of notification that the Provider is disqualified through any federal, State and/or Medicaid administrative action, the Provider will not submit claims for payment by Medicaid for services performed on or after the disqualification date.

2.6. The Provider agrees that any overpayment or improper payment may be immediately deducted from future Medicaid payments to any payee with the Provider's Tax Identification Number at the discretion of ASES.

2.7. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the Puerto Rico Legislature and/or federal sources. ASES may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective

immediately upon receipt of written notice (or any date specified therein) if for any reason ASES's funding from Puerto Rico and/or federal sources is not appropriated or is withdrawn, limited or impaired.

3. **Notices**. All written notices or communication shall be deemed to have been given when delivered in person; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify ASES or its agent within five (5) working days of any of the following:

   3.1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest or felony conviction or any criminal charge.

   3.2. Change in any ownership and control information described in 42 CFR 455 subpart B. Among other information, this will include corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Medicaid funds.

   3.3. When there is a change in ownership, the terms and agreements of the original Agreement are assumed by the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined. Change in ownership requires full disclosure of the terms of the sale agreement, a new enrollment application and a newly signed Medicaid provider contract.

4. **Records**.

   4.1. ASES is a covered entity as defined by HIPAA. Accordingly, ASES complies with the HIPAA Privacy Regulations promulgated in 45 CFR 160 and 164. In accordance with 45 C.F.R. § 164.506, when requested by ASES for treatment, payment or health care operations, Provider will furnish Protected Health Information about potential or current ASES Recipients without requiring the individual's authorization.

   4.2. Provider shall maintain adequate medical, financial and administrative records as necessary to fully justify and disclose the extent of Services provided to Recipients under this Agreement for a minimum of ten (10) years from the date of the Service. ASES, the Medicaid Fraud Control Unit ("MFCU"), U.S. Department of Health and Human Services, and any of their employees, agents or authorized representatives shall be provided access to the Provider's business or facility and all related Recipient information and records, including claims records. It is the Provider's responsibility to obtain any Recipient consent required in order to provide the requested information and records.

   4.3. Failure to timely submit or failure to retain adequate documentation for Services billed to Medicaid may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medicaid provider.

   4.4. Provider agrees to furnish all information as described in 42 CFR Part 455, subpart B, as now in effect or as may be amended, including ownership or control information.

   4.5. *For Facility Providers Only*: Provider agrees to maintain records as are necessary to fully disclose to the Recipient, his/her representative and/or ASES, the management of Recipient trust funds and upon demand transfer to the Recipient, his/her representative and/or ASES the balance of his/her Recipient trust funds held by the Provider. Upon discharge, the Provider agrees to return monies and valuables of the Recipient to him/her or, in the event of the death, to the Recipient's legal representative.

5. **Miscellaneous**.

   5.1. Both parties mutually agree that the Puerto Rico Medicaid Government Health Plan (GHP) 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.

5.2. *For Group Practices Only*: Group Practice affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. Group Practice also agrees to provide ASES with names and proof of current licensure for each member Provider as well as the name(s) of the individual(s) with authority to sign billings on behalf of the group. Group Practice agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

5.3. *For Hospital, Nursing Facility, Hospice, Home Health Agency and Personal Care Service Providers Only*: Provider shall provide all Recipients with written information regarding their rights to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives (durable power-of-attorney for health care decisions and declarations).

5.4. *For Facility Providers Only*: Provider shall cooperate in the transfer of Recipients from level to level as prescribed by the attending physician and all pertinent federal and state regulations.

5.5. *For Providers Not Defined as Covered Entities under HIPAA in 45 CFR 160*: Providers who are not required to comply with HIPAA privacy rules must inform ASES in writing and execute a business associate agreement or other appropriate confidentiality agreement concurrent with this Agreement to protect and secure the privacy of all Recipients' Protected Health Information in accordance with the HIPAA requirements of 45 CFR 160, 162 and 164.

5.6. ASES does not guarantee the Provider will receive any Recipients as clients and the Provider does not obtain any property right or interest in any Recipient business by the Agreement.

5.7. ASES may terminate this Agreement with cause at any time with twenty (20) days prior written notice to the Provider.

5.8. ASES may terminate this Agreement immediately when ASES receives notification that the Provider no longer meets the professional credential or licensing requirements, or the enrollment screening criteria described at 42 C.F.R. 455 subpart E.

5.9. It is further expressly understood and agreed that either party to this Agreement, may terminate this Agreement without cause at any time by ninety (90) days prior written notice to the other party.

The parties agree that all questions pertaining to validity, interpretation and administration of this Agreement shall be determined in accordance with the laws of Puerto Rico, regardless of where any Service is performed. The parties consent to the exclusive jurisdiction of Puerto Rico for enforcement of this Agreement.

By signature below, Provider attests that it:

- Has accepted the terms and conditions of this Provider Enrollment Agreement.
- Has provided true, correct and complete information in its Provider Enrollment Application, and will notify ASES if any of the above information is not true, correct, or complete.
- Will timely notify ASES of any changes to the information contained in its Provider Enrollment Application after enrollment, in accordance with this Agreement and applicable laws.
- Is a Covered Entity in compliance with the HIPAA privacy rule at 42 CFR 164, or has complied with section 5.5 above.
- Will pay any applicable application fees required under 42 C.F.R. § 455.460.

All matters stated herein are true and accurate, signed by a natural person who is the Provider or is authorized to act for the Provider, under the pains and penalties of perjury. I understand that by typing my first and last name in the Provider Signature field below, I have provided a legal signature confirming my acknowledgement and agreement of the above.

Provider Signature: _____ Date: _____