

The provider agreement may be canceled by either the provider or the department upon thirty days written notice prior to the termination date.

You are required to inform the department within thirty days of any changes to your provider information.

Complete the Ohio Medicaid Group Application/Agreement, attach required documentation, and mail to:

Provider Relations Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, Ohio 43266-0161

Should you have any questions regarding completion of your application/agreement form, call our Provider Enrollment Unit at:

In State 950-5627, after the dial tone, then dial 8-3288, press OPTION 2
Out of State (614) 728- 3288, press OPTION 2

Sincerely,

Wanda L. Ohler
Section Chief

98-11
SUPERVISOR
DEC 14 1998
APPROVAL DATE
11/1/98

Submit completed signed application/agreement to:
 Provider Relations Section
 Provider Enrollment Unit
 P.O. Box 1461
 Columbus, OH 43266-0161

(For State Use Only)

ODHS 6752 (Rev. 6/97)

Medicaid Provider Enrollment Application/Agreement for Practitioner Groups

Complete all applicable items if you plan to bill Medicaid as an eligible "Group" provider which must be an organization composed solely of **two or more** individuals of the same profession who are members of a professional association organized under Chapter 1785, of the Revised Code, each of whom is licensed or approved by a standard-setting or regulatory agency to render the same kind of professional service and approved participation in the Medicaid program by the Ohio Department of Human Services as an individual provider. Multiple location group providers must complete a separate Form 6752 for each location.

Group Provider Types: (Mark the appropriate type)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Physician (21) | <input type="checkbox"/> Psychologist (67) | <input type="checkbox"/> Optometrist (61) | <input type="checkbox"/> Advanced Practice Nurse (07) |
| <input type="checkbox"/> Osteopath (23) | <input type="checkbox"/> Physical Therapist (66) | <input type="checkbox"/> CRNA (57) | <input type="checkbox"/> Chiro-Mechano-therapist (68) |
| <input type="checkbox"/> Dentist (31) | <input type="checkbox"/> Podiatrist (62) | <input type="checkbox"/> Chiropractor (63) | |

Provider Identification: (Print or type entries)

Group Name _____

Abbreviated Group Name (if your name exceeds 30 spaces, indicate preferred abbreviation.) _____

Employer Identification Number _____	You must attach a signed W-9 form	Social Security Number (Proprietor) _____
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Geographic Location:

Physical Location of Group: (Groups with multiple locations must complete a separate Form 6752 for each location)

g Name / OF / Department / OF / In care of _____

Group Address (Number, Street, Avenue, Route, etc. P.O. Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if possible)
Telephone Number () _____			

"Pay to" Address (Name & Address to which Payment or Remittance Advice is to be mailed)
 (If Address is not different from "Physical Location of Group" address, leave blank)

Building Name / OF / Department / OF / In care of _____

Address			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)
 (If Address is not different from "Physical Location of Group" address, leave blank)

Building Name / OF / Department / OF / In care of _____

Address			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

TIN No. 99-009 APPROVAL DATE DEC 14 1999
 SUPERVISOR _____
 ESTABLISH DATE 11/1/99

This Form May NOT Be Duplicated

(For State Use Only)

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No"; marking the appropriate box; and/or giving the proper dates.

1. A. Have you or any individuals or organizations having a direct or indirect ownership or control interest in the professional association or practice been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

YES NO

Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____	SSN/EIN

1. B. Have you or any of the employees of your professional association or practice ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

YES NO

Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____	SSN/EIN

2. Type of Entity or Practice: Sole Proprietorship Partnership Corporation Unincorporated Associations
 Professional Corporation/Association Other (specify) _____

3. A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

YES NO

3. B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

YES NO

4. Is this entity or practice operated by a management company, or leased in whole or part by another organization? If yes, give date of change of operations. (mm/dd/yyyy)

YES NO

5. Have you or the entity or practice ever been sanctioned by the Medicare Program?

If "YES", when? (mm/dd/yyyy)

How long? (mm/dd/yyyy)

YES NO

____/____/____ From ____/____/____ to ____/____/____

Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____ to ____/____/____	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy) ____/____/____ to ____/____/____	SSN/EIN

6. Has this group ever been issued an Ohio Medicaid Provider Number?

YES NO

If, YES, you must list them in the boxes below.

Provider Number	Provider Number	Provider Number	Provider Number
-----------------	-----------------	-----------------	-----------------

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity or practice already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

TN No. 99-009 APPROVAL DATE 14 1999
 SUPERSEDES CR-11



Have you remembered...

- ..to complete, sign, date, and attach your Form **W-9**,
- ..to double check the **Application/Agreement** to make sure all applicable information has been included,
- ..to look for footnotes (*) on the Application/Agreement and attach the necessary material,
- ..to provide us with **ALL** names, addresses, and legal numbers as required,
- ..to complete **ALL** date fields,
- ..to sign and date the Application/Agreement at the bottom of page 7.

TN No. 99-009 OPERATIONAL DATE DEC 1 1999
SUPERSEDES
TN No. 98-11 EFFECTIVE DATE 7/1/99

For State Use Only

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Human Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service;
2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.
3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.
6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-173 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.
8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.
9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.
10. Provide to ODHS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Human Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".
11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

this provider agreement may be canceled by either party upon 30 days written notice prior to termination date except in the case of health maintenance organizations (HMOs) who must notify the Department in writing at least 90 days prior to the date of cancellation.

further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

For individual practitioners:

Individual Practitioner Name and Title (please print): _____

Individual Practitioner Signature: _____ Date: ____/____/____ (mm/dd/yyyy)

For groups or organizations:

Authorized Representative Name and Title (please print): _____

Authorized Representative Signature: _____ Date: ____/____/____ (mm/dd/yyyy)

ATTACH ALL COPIES OF LICENSURE, CERTIFICATION, REGISTRATION, ETC., AS REQUIRED FOR YOUR PROVIDER TYPE. APPLICATIONS SUBMITTED WITHOUT THE REQUIRED ATTACHMENTS WILL BE CONSIDERED INCOMPLETE AND RETURNED TO THE APPLICANT.

For State Use Only

Signature of Authorized Agent: _____ Date: _____

DEC 14 1999
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Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Date Processed	Effective Date	Provider Number
Operator's Number	Application Number <i>2513</i>	Ticket Number

This Form May NOT Be Duplicated

TN No. *99-009*

APPROVAL DATE

SUPERSEDES

09.11

George V. Voinovich
Governor



Attachment 4.16-I
Arnold R. Tompkins
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

Dear Provider of Medical Services:

This form is an application/agreement for enrollment in the Ohio Medicaid program as an individual practitioner. Practitioners must have individual provider agreements regardless of whether you are a member of a group with a provider agreement or an employee of an entity with a provider agreement. Medicaid reimbursement is contingent upon a valid provider agreement being in effect while the services were provided.

Each section of the application contains specific instructions for completion and may require you to attach specific information. Read each section carefully as instructions and requirements may vary for individual practitioner types. If there are blocks on the application that are not applicable to you, then leave those particular areas blank. **However, incomplete applications or completed applications without required attachments will be returned to you for correction.** Upon completion of the application, be sure to read, sign, and date the provider agreement portion of this form. Should this area be left unsigned or undated your application for enrollment will be considered incomplete and will be returned to you for completion. Properly completed applications will be processed and you will be notified by mail of your Medicaid provider status.

The department may deny a provider application/agreement for reasons including, but not limited to:

- *Any license, permit, or certificate that is required by the department has been denied, suspended, revoked or not renewed.
- *The provider is terminated, suspended or excluded by the Medicare program and/or by the federal Department of Health and Human Services and that action is binding on the provider's participation in the Medicaid program or renders federal financial participation unavailable for the provider's participation in the Medicaid program.
- *The provider has pled guilty to, or been convicted of a criminal activity materially related to either the Medicare or Medicaid program.
- *A judgement has been entered in either a criminal or civil action against a Medicaid provider or it's owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to Section 109.85 of the Revised Code.

The provider agreement may be canceled by either the provider or the department upon thirty days written notice prior to the termination date.

You are required to inform the department within thirty days of any changes to your provider information.

OHIO
the heart of it all!

An Equal Opportunity Employer

TN No. 09-009 APPROVAL DATE 1/19/99
SUPERSEDES _____
TN No. 098-11 RECEIPT DATE 7/11/01