Thank you for choosing to participate in the Mississippi Medicaid Program. The Mississippi Division of Medicaid appreciates your interest in the Medicaid Program and welcomes the opportunity to work with you to provide health care services to Mississippi Medicaid beneficiaries.

How to Complete the Application

- Please print or type.
- Complete all areas of the application, as applicable.
- In areas that are being completed, all fields must be completed or marked “N/A”.
- In areas where you need to provide more information than there is space available, please copy the page(s).
- For all date fields, use the format MM/DD/YYYY unless otherwise indicated.
- Applications with no signatures will not be processed.
- Stamped signatures will not be accepted.
- Individual provider applications must be signed by the individual.
- Sole provider applications must be signed by the individual sole provider.
- Authorized Officials must sign the Group/Organization application.
- Delegated Officials must sign the Group/Organization application, if applicable.
- All documents must be legible.
- Notification will be sent to the Mail Other Address for Provider Communications if any portion has been filled out incorrectly, or if form(s) are not completed and/or missing.

Applications and all correspondence should be sent to the Fiscal Agent:
Conduent State Healthcare, LLC
ATTENTION: Provider Enrollment
P.O. Box 23078
Jackson, MS 39225

Applications and all correspondence submitted via Fed Ex should be sent to the following physical address:
Conduent State Healthcare, LLC
ATTENTION: Provider Enrollment
385 B Highland Colony Parkway, Suite 300
Ridgeland, MS 39157

For questions regarding any portion of this application, contact a Conduent Provider Enrollment Specialist at 1-800-884-3222.

About the Application Packet
The application packet contains the following **and is subject to change**:

Reference Materials – Section A
(Helpful information that can assist you in completing the enrollment application)
- Frequently Asked Questions (FAQs) (A-1)
- Conduent Contact Information (A-2)
- Additional Credentialing Requirements (A-3)
- Provider Risk Levels Information (A-4)

Basic Application Material – Section B (To be completed by all providers)
- Mississippi Medicaid Provider Enrollment Application

Required Enrollment Forms – Section C
- Medical Assistance Participation Agreement (C-1)
- Provider Disclosure Form (C-2)
- Civil Rights Compliance Information Request for Medicaid Certification (C-3)
- Direct Deposit Authorization Agreement (C-4)
- W-9 Taxpayer Identification Number Request (C-5)

Additional Enrollment Forms – Section D
(To be reviewed by all providers and completed as applicable)
- CLIA Information Form (D-1)
- EDI Provider Agreement (if submitting claims electronically) (D-2)

Frequently Asked Questions (FAQs)
Section A-1

Q.	**How long does it take to process an enrollment application?**
A.	The Fiscal Agent should complete the initial review of the enrollment process within five (5) business days of receipt of a correctly completed application. The application will then be sent to the Division of Medicaid (DOM) for the final review. Incomplete applications are returned. To avoid delays, please ensure all applications are complete with the required forms and attachments.
Q.	**Should I hold claims until I receive a provider number?**
A.	Yes, this will avoid claims denial.
Q.	**Do I have to participate in Direct Deposit?**
A.	Yes, all providers must participate in Direct Deposit.
Q.	**Why do we have to have a W-9?**
A.	The W-9 is required by the IRS.
Q.	**Why do we have to submit verification of Social Security and/or federal identification numbers for providers?**
A.	DOM must verify social security and federal tax identification numbers in order to comply with IRS requirements.
Q.	**How do I change an address?**
A.	Complete and submit a Change of Address Form to update your address information and prevent non-receipt of communication from DOM. Go to https://medicaid.ms.gov/wp-content/uploads/2014/06/ProviderChangeofAddressForm.pdf to download the form. You may submit the form by mail to Conduent at P.O. Box 23078, Jackson, MS 39225 or by fax to1-888-495-8169.
Q.	**What is an NPI number?**
A.	A National Provider Identifier or NPI is a unique 10-digit identification number issued to **health care** providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
Q.	**What is the NPPES Enumerator?**
A.	Registry developed by CMS to assign standard unique identifiers (NPI numbers) for healthcare providers.
Q.	**What is Medicaid's definition of a Re-enrollment?**
A.	A provider whose Medicaid number has been terminated or closed and the provider is completing an application to reapply.

Frequently Asked Questions (FAQs)
Section A-1 Continued

Q. What is Medicaid's definition of a Group/Organization?

A. A Group/Organization provider is not an individual/sole proprietor. This includes hospitals, long-term care facilities, laboratories, home health agencies, ambulance companies, and group practices; suppliers of durable medical equipment or pharmacies. Any subpart of the group/organization must apply for a different Medicaid provider number as determined by the provider type per Medicaid rule. A group provider requesting individual providers/servicing providers to be affiliated to their billing provider number must be approved Medicaid providers. For monies to be reported to the IRS on its Tax Identification, the group provider should be the biller, unless otherwise restricted by the Division of Medicaid. Group providers that have various servicing locations should apply to Medicaid to become a provider according to their numeration application with CMS. The provider should also apply to Medicaid to become a provider according to the conduct of their own standard transactions and as required by the Division of Medicaid's program rules.

Q. What is the Provider Disclosure Form?

A. A document to be completed by all Mississippi Medicaid providers at application submission; upon change of required disclosing information; at re-validation of enrollment; and within thirty-five (35) days after any change in ownership of the provider; and/or upon request by Mississippi Medicaid. The Code of Federal Regulations set forth in 42 CFR. §§ 455.100-106 requires that all providers disclose specified information regarding business ownership and control, business transactions, and criminal convictions to the Mississippi Division of Medicaid (DOM). In addition, state law provides that Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These disclosures will be used to determine the applicability of Miss. Code Ann. § 43-13-121(7).

Q. What is Medicaid's definition of a Sole Proprietor?

A. A Sole Proprietor is a form of business in which one (1) person owns all of the assets of the business and is solely liable for all debts on an individual basis. As a result of the National Provider Identifier (NPI) requirements, a Sole Proprietor must apply for their NPI as individuals. Medicaid will no longer issue a group number to an individual effective with the adoption of this rule revision. The subpart concept does not apply to a sole proprietorship, even one (1) with multiple locations, because the sole proprietorship is not an organization as defined in the final NPI Rule. An individual Medicaid provider number and the appropriate NPI issued by the Centers for Medicare and Medicaid Services (CMS) are entered into the Medicaid system with the individual's social security number (SSN); and if applicable, the Federal Employer Identification Number (FEIN) assigned to it. If this number is used as a Medicaid provider billing number, income or earnings information are reported to the IRS for this SSN or FEIN, as applicable. Deferred compensation is only available via a sole proprietor's SSN.

Frequently Asked Questions (FAQs)
Section A-1 Continued

Q.	**Our facility is a participant in the 340B program. Does the facility only have to file the attestation form, or do individual providers also need to complete the attestation form?**
A.	This form is only for facilities, i.e., billing providers. Registration should reflect the same information as provided to HRSA regarding program enrollment. As such, the 340B attestation form has been submitted to each provider issued a unique HRSA 340B identification number. DOM requires that all providers carving in 340B medications provide all HRSA-issued 340B identification numbers with their attestation form. Since the possibility exists of participating Mississippi Medicaid providers having a "one to many" NPI number, for example, when several Mississippi Medicaid Provider ID numbers associated with a single NPI number, DOM must validate the individual 340B ID numbers as either electing to opt-in or opt-out of billing 340B-purchased drugs to DOM. Providing each 340B ID will help the state identify and validate providers which may share the same billing NPI.
Q.	**Am I eligible to receive Primary Care Provider (PCP) Increased Payments?**
A.	Eligible providers must be able to attest to board certification by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) as a specialist or sub-specialist in family medicine, general internal medicine or pediatric medicine. Eligible providers who do not have an ABMS, ABPS, or AOA certification must attest as a specialist/sub-specialist in family medicine, general internal medicine or pediatric medicine and attest at least 60% of their total Medicaid paid codes are for specific Evaluation and Management (E&M) and Vaccine Administration codes. Self-attested Mississippi Medicaid providers are eligible for an increased payment of 100% of the Medicare rate for certain primary care services.
Q.	**How do I self-attest to receive Primary Care Provider Increased Payments?**
A.	Once enrolled, an eligible provider must complete, sign and date Section I of the PCP Self-Attestation Statement form. The PCP Self-Attestation form can be found on the Medicaid website at https://medicaid.ms.gov/resources/forms/. Completed forms must be submitted to Conduent Provider Enrollment via: Email msinquiries@conduent.com, Fax 888-495-8169, or Postal mail P.O. Box 23078, Jackson, MS 39225.

Frequently Asked Questions (FAQs)
Section A-1 Continued

Q.	Am I eligible to receive Obstetrician/Gynecologist (OB/GYN) Primary Care Provider (PCP) Increased Payments?
A.	Once enrolled, an eligible provider must be able to attest to board certification by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or sub-specialist in obstetric/gynecologic (OB/GYN) medicine. Eligible providers who do not have an ACOG certification must attest as a specialist/sub-specialist in obstetric/gynecologic (OB/GYN) medicine and attest at least 60% of their total Medicaid paid codes are for specific Evaluation and Management (E&M) and Vaccine Administration codes. Self-attested Mississippi Medicaid providers are eligible for an increased payment of 100% of the Medicare rate for certain primary care services.
Q.	**How do I self-attest to receive Obstetrician/Gynecologist (OB/GYN) Primary Care Provider (PCP) Increased Payments?**
A.	Once enrolled, an eligible provider must complete, sign and date Section I of the OB/GYN PCP Self-Attestation Statement form. The OB/GYN PCP Self-Attestation form can be found on the Medicaid website at: https://medicaid.ms.gov/resources/forms/. Completed forms must be submitted to Conduent Provider Enrollment via: Email msinquiries@conduent.com, Fax 888-495-8169, or Postal mail P.O. Box 23078, Jackson, MS 39225.
Q.	**What is the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program?**
A.	The EPSDT program is a federally mandated service which provides preventive and comprehensive health services for children from birth up to age 21 who are eligible for Medicaid. It provides critical services to improve the health of infants, children and adolescents. It provides a way for children to get medical exams, checkups, follow-up treatment, and special care they need to make sure they enjoy the benefits of good health.
Q.	**How do I become an EPSDT Provider?**
A.	Once enrolled, a physician, physician assistant or nurse practitioner who wishes to provide EPSDT screenings must complete and sign an EPSDT specific provider agreement and pass an onsite clinic inspection performed by the Division of Medicaid. The EPSDT provider agreement is located at https://medicaid.ms.gov/wp-content/uploads/2017/04/EPSDT-Provider-Agreement.pdf.
Q.	**What is the Vaccine for Children (VFC) program?**
A.	The Vaccines for Children program is a federally funded and state operated program that began October 1994. The program provides vaccines free of charge to VFC eligible children through public and private providers. Eligible children include those who receive Medicaid, Native Americans or Alaskan Natives, and children who have health insurance that does not cover vaccination. Providers are reimbursed by Medicaid for vaccine administration only.

Frequently Asked Questions (FAQs)
Section A-1 Continued

Q.	**How do I become a VFC Provider?**
A.	The Mississippi Department of Health (MSDH) is the lead agency for the VFC program. To enroll as a provider, please contact the MSDH Division of Immunization at (601) 576-7751 or 1-800-634-9258. MSDH forwards all approved VFC applications to DOM. You must also be enrolled as MS Medicaid provider to receive reimbursement from DOM.
Q.	**What is the Healthier MS Waiver (HMW), and are there provider specific requirements to render services to HMW beneficiaries?**
A.	The HMW allows MS Medicaid to provide all state plan services, except for long-term care services (including nursing facility and home and community based waivers), swing bed in a skilled nursing facility, and maternity and newborn care to individuals with income up to one hundred and thirty five percent (135%) of the federal poverty level (FPL) who are aged or disabled, are not eligible for Medicare, and are not eligible under the Medicaid state plan. Providers licensed to practice in the state of Mississippi and enrolled as a MS Medicaid provider may provide services to HMW participants.
Q.	**What is the Family Planning Waiver (FPW), and are there provider specific requirement to render services to HMW beneficiaries?**
A.	The Family Planning Waiver program covers family planning and family planning related waiver services and supplies for women and men, ages thirteen (13) through forty-four (44), who are capable of reproduction, who would not otherwise qualify for Medicaid, and with incomes at or below one hundred eighty-five percent (185%) of the federal poverty level, converted to a Modified Adjusted Gross Income (MAGI) equivalent standard. Beneficiaries are limited to total of four visits per federal fiscal year (Oct. 1-Sept. 30). These beneficiaries are not eligible to receive any other Medicaid benefits. Providers licensed to practice in the state of Mississippi and enrolled as a MS Medicaid provider may provide services to FPW participants.
Q.	**How do I submit additional information if enough space is not provided?**
A.	In areas where you need to provide more information than there is space available, copy the page(s) and submit with the application.
Q.	**Who can provide Mental Health Services, and what services can they provide?**
A.	This information is currently available on the Mississippi Division of Medicaid website and is accessible at the following link: https://medicaid.ms.gov/programs/mental-health/.

CONDUENT State Healthcare, LLC
Contact Information
Section A - 2

The FA provides services which include lines for provider inquiries, automated eligibility verification and assistance with electronic claim submittal. The call center is open Monday through Friday, 8 am-5 pm CST.

Provider/Beneficiary Services (Call Center)
1-800-884-3222
Provider/Beneficiary Services Fax Number
1-888-495-8169
Automated Voice Response System
1-800-884-3222
Web Address
www.ms-medicaid.com

Additional Credentialing Requirements for MS Medicaid Participation Section A-3

This checklist serves as a guide to understanding what additional information is needed to enroll/re-enroll as a Medicaid provider.

REQUIREMENTS

as of May 7, 2018

Provider Type Code	Description	Provider License or Permit	NPI Verification (NPPES)	SSN Verification	Medicare Certification	Joint Commission Approval	Approved Medicare Cost Report	CLIA	DMH Certification	MS Board of Pharmacy Permit	ASHA	Certificate of Disease Management	Tax ID Verification	State Dept. of Health License	Medicaid Approval Letter ******	Medicaid Approved Proposal Letter *****
A00	Physician MD	✓	✓	✓				✓								
A05	Doctor Of Osteopathy	✓	✓	✓				✓								
A06	Crossover Only *	✓	✓	✓	✓								✓			
A08	Chiropractor	✓	✓	✓												
A09	Podiatrist	✓	✓	✓												
B00	Independent Lab		✓					✓					✓			
B01	Independent Diagnostic Testing Facility		✓		✓								✓			
C01	Nutritionist/Dietician	✓	✓	✓	✓											
D01	Hospital, Nonprofit General	✓	✓		✓			✓					✓			
D05	Hospital, Psychiatric	✓	✓		✓			✓					✓			
D06	Hospital, Proprietary General	✓	✓		✓			✓					✓			
DP0	Psychiatric Residential Tmt Cn	✓	✓			✓		✓					✓			
DS0	Hospital, Swingbed	✓	✓		✓								✓			
EC0	Expanded Srvs/ School Hlth Related Srv **	✓	✓										✓			
ED0	School Based Screen RN ***	✓	✓										✓			
G02	ICF, Nonprofit Mental	✓	✓					✓					✓			
G07	ICF, Proprietary Mental	✓	✓					✓					✓			
H01	Pharmacies, Closed Door		✓							✓			✓			
H02	Pharmacies, Retail		✓							✓			✓			
H04	Pharmacy Disease Management	✓	✓	✓								✓				
H07	Pharmacies, Institutional		✓							✓			✓			
I00	DME, Medical Equip Supplies		✓		✓					✓			✓			
I01	DME, Home Health		✓		✓					✓			✓			
I03	DME, Pharmacy Based, Community		✓		✓					✓			✓			
J00	Ambulance	✓	✓										✓			
K00	Dentist, Unclassified	✓	✓	✓												
L00	HHA Unclassified	✓	✓		✓								✓			
L01	HHA Public Health Agency	✓	✓		✓								✓			
L02	HHA Hospital Based Program	✓	✓		✓								✓			
L08	Hospice	✓	✓		✓								✓			
M00	Audiologist	✓	✓	✓							✓					
M01	Hearing Aid Dealer	✓	✓	✓							✓		✓			
N00	Optometrist	✓	✓	✓												
N01	Optical Dispensary		✓										✓			
O00	Rural Health Clinic	✓	✓		✓			✓					✓			
O02	Federally Qualified Health Center		✓		✓		✓	✓					✓			
Q01	Kidney Dialysis Freestanding		✓		✓								✓			
Q02	Kidney Dialysis Hospital Based		✓		✓								✓			

* Application can be for an Individual or Group Provider. If applying as an individual provider, the SSN Verification is required. If applying as a group provider, the Tax ID Verification is required.

** The EPSDT School Health Related Provider Agreement located at https://medicaid.ms.gov/wp-content/uploads/2017/04/EPSDT-School-Health-Related-Provider-Agreement-Only-schools-applying-for-Expanded-Health-Services-that-employ-active-Medicaid-Physical-Occupational-and-Speech-Therapists-should-complete-this-agreement.pdf and a letter from the school superintendent are required documents.

*** The EPSDT Provider Agreement located at https://medicaid.ms.gov/wp-content/uploads/2017/04/EPSDT-Provider-Agreement.pdf and a letter from the school superintendent are required documents.

ADDITIONAL CREDENTIALING REQUIREMENTS FOR MS MEDICAID PARTICIPATION SECTION A-3

This checklist serves as a guide to understanding what additional information is needed to enroll/re-enroll as a Medicaid provider.

REQUIREMENTS

as of May 7, 2018

Provider Type Code	Description	Provider License or Permit	NPI Verification (NPPES)	SSN Verification	Medicare Certification	Joint Commission Approval	Approved Medicare Cost Report	CLIA	DMH Certification	MS Board of Pharmacy Permit	ASHA	Certificate of Disease Management	Tax ID Verification	State Dept. of Health License	Medicaid Approval Letter ******	Medicaid Approved Proposal Letter *****
S00	Nurse Anesthetist	✓	✓	✓												
S01	Nurse Midwives	✓	✓	✓												
S02	Nurse Practitioner	✓	✓	✓												
S05	Private Duty Nursing	✓	✓										✓			
S06	Physician Assistant ****	✓	✓	✓												
S07	Prescribed Pediatric Extended Care Center		✓										✓	✓		
T00	Occupational Therapists	✓	✓	✓												
T01	Physical Therapists	✓	✓	✓												
T02	Speech/Language Pathologists	✓	✓	✓							✓					
T04	Comprehensive OP Rehab Facility		✓		✓								✓			
V00	Ambulatory Surgical Centers		✓		✓								✓			
V01	Birthing Centers		✓		✓								✓	✓		
W00	Case Management *****		✓						✓				✓			✓
W01	Homemaker Svcs (Personal Care Svcs) *****												✓			✓
W02	Respite Care, Institutional *****								✓				✓			✓
W03	Respite Care, In Home *****								✓				✓			✓
W04	Adult Day Care *****		✓										✓			✓
W05	Home Delivered Meals *****												✓			✓
W06	Personal Care Attendant *****								✓				✓			
W07	Habilitation *****								✓				✓			
W08	Multiple Services Providers, HCBS *****		✓						✓				✓			✓
WC0	Assisted Living Services Prov *****		✓										✓	✓		✓
X00	Community Mental Health		✓						✓				✓			
X01	Private Mental Health		✓						✓				✓			
X02	Social Worker (LCSW Only)	✓	✓	✓												
X03	Psychologist	✓	✓	✓												
X04	MYPAC ******		✓						✓				✓		✓	
X05	IDD Community Support Program		✓						✓				✓			
X07	Licensed Professional Counselor	✓	✓	✓												
X08	Board Certified Behavior Analyst (BCBA)	✓	✓	✓												
Y00	NF, Nonprofit *******	✓	✓										✓			
Y02	NF, State Owned *******	✓	✓										✓			
Y03	NF, County Owned *******	✓	✓										✓			
ZA0	Group, Physicians		✓										✓			
ZK0	Group, Dentist		✓										✓			
ZM0	Group, Hearing		✓										✓			
ZN0	Group, Optical		✓										✓			
ZP0	Group, Pharm Disease Management		✓										✓			
ZS0	Group, Nursing Services		✓										✓			
ZT0	Group, Therapist		✓										✓			
ZX0	Group, Mental Health		✓										✓			

**** If servicing state is Mississippi, a copy of the protocol approved by the MS Board of Medical Licensure is required.

***** DMH certification or Medicaid Approved Proposal letter is required based on the services provided. If questions, contact DOM's Office of Mental Health at 800-421-2408 or (601)359-9545 or Office of Long Term Care at 800-421-2408 or (601) 359-6141.

****** Medicaid approval letter is required with the MYPAC application. If questions, contact DOM's Office of Mental Health at 800-421-2408 or (601) 359-9545.

******* Go to https://medicaid.ms.gov/wp-content/uploads/2015/01/Addendum_NursingFacilityVent.pdf to obtain the Addendum for Nursing Facility Ventilator Dependent Care Services.

Risk levels assigned for enrolling and re-validating Medicaid providers based on 42 CFR § 455.450

Limited Risk (Federal database checks)

Provider	Code	Provider	Code
Physician	A00	Kidney Dialysis	Q01, Q02
Doctor of Osteopathy	A05	State Board of Health	R00
Crossover Only Provider	A06	Certified Nurse Anesthetist	S00
Chiropractor	A08	Nurse Midwife	S01
Podiatrist	A09	Nurse Practitioner	S02
Nutritionist	C01	Physician Assistant	S06
Hospital	D01, D05 & D06	Prescribed Ped Extended Care	S07
Psych Residential Treatment Facility	DP0	Occupational Therapist	T00
Swing Bed	DS0	Speech Language Therapist	T02
Expanded Services/Health Related	EC0	Ambulatory Surgical Center	V00
School Based Screener RN	ED0	Birthing Centers	V01
Intermediate Care Facility MR	G02 & G07	Respite Care, Institutional	W02
Pharmacy	H01, H02, H07	Licensed Certified Social Workers	X02
Pharmacist Disease Management	H04	Psychologist	X03
Dentist	K00	MYPAC	X04
Audiologist	M00	Licensed Professional Counselor	X07
Hearing Aid Dealer	M01	Nursing Facilities	Y00, Y01, Y02, Y03
Optometrist	N00	Physician Group	ZA0
Optical Dispensary	N01	Dental Group	ZK0
Rural Health Clinic	O00	Hearing Group	ZM0
Federally Qualified Health Center	O02	Optical Group	ZN0
ORP (Ordering, Referring, Prescribing)	ORP	Pharmacist-Disease Mgt. Group	ZP0

Moderate Risk (Federal database checks/site visits)

Provider	Code	Provider	Code
Independent Lab	B00	Physical Therapist	T01
Independent Diagnostic Testing Facility	B01	Comprehensive Outpatient Rehab	T04
Ambulance	J00	Assisted Living	WC0
Private Duty Nursing Agency	S05	Therapist Group	ZT0

HIGH RISK (Federal database checks/site visit/fingerprinting & criminal background checks)

Provider	Code	Provider	Code
Durable Medical Equipment	I00, I01, I03	Personal Care Attendant	W06
Home Health	L00, L01, L02	Habilitation	W07
Hospice	L08	Multiple Services (HCBS)	W08
Case Management	W00	Community Mental Health	X00
Personal Care Services	W01	Private Mental Health	X01
Respite Care, In Home	W03	Community Support Program	X05
Adult Day Care	W04	Mental Health Group	ZX0
Home Delivered Meals	W05		

NOTE: Pursuant to 42 CFR § 455.450(e), particular providers will automatically be "bumped up" to the high risk category due to payment suspension based on credible allegation of fraud, waste or abuse; existing Medicaid overpayment at the time of enrollment or revalidation; excluded by the OIG or another state's Medicaid program within the previous 10 years and/or lifting of a temporary moratorium within the state or by CMS within the previous 6 months. (Updated xxxx2018)

MISSISSIPPI MEDICAID ENROLLMENT APPLICATION

SECTION B (Pages 1 – 12)

SECTION 1 – GENERAL INFORMATION

Select an applicant type (check one):	
☐	An Individual *Check here if this application is for an individual that does not have an Employer Identification Number (EIN).*
☐	A Group/Organization *Check here if this application is for a corporation, a partnership, or other business that has an EIN.*
☐	A Sole Proprietor *Check here if this application is for an individual that has an Employer Identification Number (EIN).*

This application is (check one):	
☐	An Initial Enrollment
☐	A Change Of Ownership
☐	Re-Enrollment *Check here if this application is for a provider whose Medicaid number has been terminated or closed and the provider is reapplying for enrollment.*

Individual Applicant Information (Legal Name as Reported to IRS)		
Last Name (including suffix)	*First Name*	*MI*
Title (M.D., D.O., etc.)	*Date of Birth*	*Gender of Provider (M/F)*

Doing Business As (DBA) Name (different than Legal Name)			
DBA Last Name (including suffix)	*First Name*	*MI*	*Title (M.D., D.O., etc.)*

Alias Name of Individual Applicant		
Last Name (including suffix)	*First Name*	*MI*

Group/Organization Applicant Information	
Group/Organization Name (as reported to the Internal Revenue Service (IRS))	*DBA Name*

Sole Proprietor Applicant Information	
Sole Proprietor Name (as reported to the Internal Revenue Service (IRS))	*DBA Name*

NPI (National Provider ID)	
Primary NPI	*Secondary NPI (if applicable)*

Type of Group/Organization (check one): (not applicable for individual or sole proprietor applicants)			
☐	Corporation	☐	Non profit
☐	Partnership/limited liability partnership	☐	Limited Liability Company
☐	Government owned		

Section 1 – General Information continued

Contact Person Information to answer questions about application		
Title (M.D., D.O., etc.)	*First Name*	*Last Name (including suffix)*
Telephone	*Fax*	*Email*

Servicing Address	
Street Address (A P.O. Box is not acceptable)	
Street Address Line 2 (Suite Number, etc.)	
City, State and Zip Code	*County*
Telephone	*Fax*

Servicing Address Contact Person		
Last Name (including suffix)	*First Name*	
Telephone	*Fax*	*Email*

Billing Address		
Street Address Line1/P.O. Box		
Street Address Line 2 (Suite Number, etc.)		
City, State and Zip Code	*County*	*Telephone*

Billing Address Contact Person		
Last Name (including suffix)	*First Name*	
Telephone	*Fax*	*Email*

Mailing Address for Remittance Advices		
Street Address Line1/P.O. Box		
Street Address Line 2 (Suite Number, etc.)		
City, State and Zip Code	*County*	*Telephone*

SECTION 1 – GENERAL INFORMATION CONTINUED

Mail Other Address for Provider Communications (Revalidation, Terminations, etc.)		
Street Address Line 1/P.O. Box		
Street Address Line 2 (Suite Number, etc.)		
City, State and Zip Code	*County*	*Telephone*

Mailing Address for 1099		
Street Address Line1/P.O. Box		
Street Address Line 2 (Suite Number, etc.)		
City, State and Zip Code	*County*	*Telephone*

Additional Servicing Address for Group/Organization Only (If you have more than one (1) additional servicing address associated with the enrolling NPI, submit a separate document listing the additional physical addresses, contact information, and servicing phone number(s) for each additional servicing location.)	
Street Address (A P.O. Box is not acceptable)	
Street Address Line 2 (Suite Number, etc.)	
City, State and Zip Code	*County*
Telephone	*Fax*

Additional Servicing Address Contact Person		
Last Name (including suffix)	*First Name*	
Telephone	*Fax*	*Email*

SECTION 2 – TAX REPORTING INFORMATION

Individual Applicant	
Enter the enrolling provider's Social Security Number (SSN).	*SSN*
Important: You must attach a copy of some form of Social Security Number verification – a copy of your Social Security Card, Driver's License, Military ID or Notarized Statement for verification of Social Security Number on W-9. *Note: Your SSN will be linked to your Medicaid provider number. All claims paid to your Medicaid provider number will be submitted as income under your SSN to the IRS. If you plan to bill using an Employer Identification Number (EIN), the group through whom you plan to bill must complete a separate application and list you as an affiliated member which links you to their EIN.*	

Group/Organization/Sole Proprietor Applicant	
Enter the enrolling group, organization, or sole proprietor's Employer Identification Number (EIN).	*EIN*

SECTION 3 – ELIGIBILITY/LICENSURE/CERTIFICATION INFORMATION

Please indicate the type of provider for which you are enrolling. **Select only one provider type per application.**

√	*Provider Type*
	Crossover Only Provider
	Crossover Only
	Dentist
	Dental Clinic/Group
	Dentist
	Durable Medical Equipment (DME)
	Home Health
	Medical Equipment Supplies
	Pharmacy Based, Community
	EPSDT (Screening/Diagnostic)
	Expanded Services/School Health Related
	School Based Screener RN
	Health Clinics
	Federally Qualified Health Center
	Rural Health Clinic
	Hearing Provider
	Audiologist
	Hearing Aid Dealer
	Hearing Clinic/Group Audiologist
	Home Health Agency
	Hospital Based
	Public Health
	Unclassified
	Hospice
	Hospice
	Hospitals
	Nonprofit General
	Proprietary
	Psychiatric
	Psychiatric Residential Treatment Facility (PRTF)
	Swing bed
	Independent Laboratory
	Independent Diagnostic Testing Facility Crossover Only (IDTF)
	Independent Laboratory
	Intermediate Care Facility (ICF)
	Non-profit Mental
	Proprietary Mental
	Kidney Dialysis Facilities
	Freestanding
	Hospital Based
	Mental Health Services
	Board Certified Behavior Analyst (BCBA)
	Community Mental Health Center
	IDD Community Support Program
	Licensed Professional Counselor (LPC)

√	*Provider Type*
	Mental Health Services (continued)
	Mental Health Clinic/Group (Psychologists, Social Workers (LCSWs), BCBAs, LPCs)
	MYPAC
	Private Mental Health Center
	Psychologist
	Social Worker (LCSW Only)
	Nurse Services
	CRNA
	Nurse Clinic/Group (Nurse Practitioner, Physician Assistant)
	Nurse Midwife
	Nurse Practitioner
	Physician Assistant
	Prescribed Pediatric Extended Care Center
	Private Duty Nursing Agency
	Nursing Facilities
	County-owned
	Non-profit
	Proprietary
	State-owned
	Nutritionist/Dietician
	Dietician (Crossover Only)
	Nutritionist (Crossover Only)
	Optical
	Optician/Optical Dispensary
	Optometric Clinic/Group
	Optometrist
	Pharmacy
	Closed Door/Specialty
	Institutional
	Pharmacist – Disease Management
	Pharmacy – Disease Management Group
	Retail Community Pharmacy
	Physician and Related
	Chiropractor
	Osteopath – DO
	Physician – MD
	Physician Clinic (and/or related, i.e. Osteopath, Chiropractor, Podiatry)
	Podiatrist
	Surgical Center
	Ambulatory Surgical Center
	Birthing Center
	Therapist
	Comprehensive Outpatient Rehab Facility (CORF) Crossover Only
	Occupational Therapist
	Physical Therapist

SECTION 3 – ELIGIBILITY/LICENSURE/CERTIFICATION INFORMATION CONTINUED

Please indicate the type of provider for which you are enrolling. **Select only one provider type per application.**

√	*Provider Type*
	Therapist (continued)
	Speech Language Pathologist (SLP)
	Therapy Clinic/Group (OT, PT, and SLP)
	Transportation
	Ambulance

√	*Provider Type*
	Waiver Services (*IDD waiver applicants are required to submit Department of Mental Health certification as an enrollment requirement. Contact the Office of Mental Health at 800-421-2408 or (601) 359-9545 with any questions. Long Term Care waiver applicants are required to submit the Medicaid Approved Proposal letter as an enrollment requirement. Contact the Office of Long Term Care at 800-421-2408 or (601) 359-6141 with any questions. Applications submitted without the appropriate documentation will be returned.)*
	Adult Day Care
	Assisted Living
	Case Management
	Habilitation
	Home Delivered Meals
	Multiple Services Provider for HCBS
	Personal Care Attendant
	Personal Care Services
	Respite Care, In Home
	Respite Care, Institutional

License Certification Information

Enter information pertaining to your current licensure and specialty, if applicable. Refer to the Credentialing Requirements list (Section A-3) for additional required licensure information per provider category.

License/Certification Number	*State*	*Board Name*

Effective Date	*Expiration Date*

Additional License Information, if applicable

License/Certification Number	*State*	*Board Name*

Effective Date	*Expiration Date*

Specialty Information, if applicable

Enter all specialties for which you are certified or eligible.

Specialty Type	*Certification Number*	*State*

Board Name	*Effective Date*	*Expiration Date*

Additional Specialty Information, if applicable

Specialty Type	*Certification Number*	*State*

Board Name	*Effective Date*	*Expiration Date*

SECTION 3 – ELIGIBILITY/LICENSURE/CERTIFICATION INFORMATION CONTINUED

Physician (i.e. Physician – MD, Osteopath – DO, Chiropractor or Podiatrist), Physician Assistant, Nurse Practitioner, or Dentist Applicant, complete this area.

If you have a Drug Enforcement Administration (DEA) Number on file with the DEA, enter it here.	*DEA Number*

Pharmacy Applicant (i.e. Retail Community, Institutional, Closed Door/Specialty, Pharmacy Disease Management), complete this area.

Enter your National Association Board Pharmacy Number.	*NABP Number*

Pharmacist-in-Charge Information

Last Name (including suffix)	*First Name*	*MI*	*Title (M.D., D.O., etc.)*

Hospital (i.e. Nonprofit General, Psychiatric, Proprietary, PRTF or Swing Bed Facility), Nursing Facility (i.e. Nonprofit, Proprietary, State-owned or County-owned), ICF (i.e. Nonprofit Mental or Proprietary Mental), Applicant, complete this area.

Enter the following information regarding beds located at your facility.

Total Number of Beds	*Number of Medicaid-Only Certified Beds*	*Number of Dually-Certified Beds*

Administrator/Contact Person at Facility Information

Last Name (including suffix)	*First Name*	*MI*

Telephone	*Fax*	*Email*

Complete this section if applicable.

Have you increased your bed capacity by 10% or more or by ten (10) beds, whichever is greater, within the last two (2) years?	☐ Yes	☐ No

If yes, provide information about the change below.

Year of Change	*Current Beds*	*Prior Beds*

Is this group/organization a provider-based facility?	☐ Yes	☐ No

Does this organization file a consolidated cost report under another's Medicaid provider number?	☐ Yes	☐ No
If yes, give the other Medicaid provider number.		

Are you a 340B provider? If yes, go to https://medicaid.ms.gov/providers/pharmacy/340b-program/.	☐ Yes	☐ No

SECTION 4 – GROUP AFFILIATION/GROUP MEMBERS

Individual & Sole Proprietor Applicants

List all groups that also participate in the Mississippi Medicaid program to which you want to be linked.

Medicaid Provider Number	*Name of Practice*	*Effective Date of Affiliation*

Important: When performing a service for a group to which you are linked, the group must bill the service under its Mississippi Medicaid group provider number or you will be paid under your individual or sole proprietor provider number and will be responsible for reporting this as income for IRS purposes.

NOTE: If you want to be linked to more than five (5) groups, please attach a separate sheet of paper providing the information requested for each additional group.

Group Applicants

List all individual providers who also participate in the Mississippi Medicaid program that should be linked to the group.

Medicaid Provider Number	*Social Security Number*	*Provider Name (Last Name, First Name, Middle Initial)*

Important: When an individual provider performs a service for a linked group, the group must bill the service under its Mississippi Medicaid group provider number or the payment will go to the individual's provider number and be reported as income for that individual to the IRS.

NOTE: If there are more than seven (7) individual providers that should be linked to the group, please attach a separate sheet of paper providing the information requested for each additional individual.

SECTION 5 – PREVIOUS PROVIDER ENROLLMENT INFORMATION

Was the enrolling provider previously participating in the Mississippi Medicaid program?		☐ Yes	☐ No
If yes, list your previously assigned Medicaid provider number(s), date(s) of enrollment and SSN(s) or EIN(s).			
Medicaid Provider Number	*Effective Date*	*Expiration Date*	*SSN or EIN*

SECTION 6 – PREVIOUS OWNER INFORMATION

Change of Ownership			
Complete this section if a Change of Ownership has occurred.			
Previous Owner Information			
Owner Name (Last Name, First Name)	*Group/Organization Name*		
New Owner Information			
Owner Name (Last Name, First Name)	*Group/Organization Name*		
Give Effective Date of New Ownership (MM/DD/YYYY):			
Are you currently using the previous Medicaid provider number?		☐ Yes	☐ No
If yes, give the Medicaid provider number here.			

SECTION 7 – FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspension for the enrolling provider named in Section 1. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

NOTE: Owners and managing/directing employee information must be disclosed in the Medicaid Provider Disclosure Form.

Convictions

(1) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,
(2) Has been convicted of a crime reference in Miss. Code Ann. § 43-13-121(7)(c)-(h), or
(3) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7) (c)-(h).

Exclusions, Revocations or Suspensions

(1) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
(2) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
(3) Has had his/her/its license or certification revoked, or
(4) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

SECTION 7 – FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS CONTINUED

Final Adverse Legal Action History

1. Has the enrolling provider named in Section 1, under any current or former name or business identity, ever had a final adverse legal action imposed?

   ☐ Yes – Continue Below ☐ No - Skip to Section 8

2. If yes, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any.

   Provide a copy of the final adverse legal action documentation and resolution.

Final Adverse Legal Action		*Date (MM/DD/YYYY)*
Taken By	*Resolution*	
Final Adverse Legal Action		*Date (MM/DD/YYYY)*
Taken By	*Resolution*	

SECTION 8 - MEDICARE

Is the enrolling provider currently enrolled in Medicare?	☐ Yes	☐ No
Indicate any Medicare numbers assigned by the Medicare intermediary to the enrolling provider.		
Medicare Number	*Medicare Number*	*Medicare Number*

SECTION 9 – REQUESTED EFFECTIVE DATE

Please indicate the requested effective date for consideration.	*Date (MM/DD/YYYY)*

NOTE: The effective date is the earliest date a provider may begin billing for services. If applicable, the provider's licensure documentation must be submitted to cover the dates of service requested. The Mississippi Division of Medicaid has sole discretion in determining the final retroactive effective date.

Section 10 – Certification And Signatures

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide by all applicable state and federal law, regulations, policies, and requirements of the Medicaid program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to make or report changes and updates to the provider's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Delegated officials may not delegate their authority to any other individual. Authorized officials may delegate only their authority to make changes and/or updates to the provider's Medicaid status. However, even when delegated officials are reported in this application, an authorized official shall retain the authority to make any such changes and/or updates by providing his or her printed name, signature and date of signature as required in this section.

NOTE: Authorized officials and delegated officials must be reported in Section B of the Mississippi Division of Medicaid Provider Disclosure Form. By his/her signature(s), an authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicaid program if any requirements are not met. E-signatures and stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider and (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicaid Fiscal Agent if any information furnished on the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Mississippi Division of Medicaid of any future changes to the information contained in this form, after the provider is enrolled in Medicaid and within thirty (30) days of the effective date of the change.

The provider can have as many authorized officials as it wants. If the provider has more than one (1) authorized official, copy, and complete this section as needed.

Certification Statement

1. I have read the contents of the application and certify that the information contained herein is true, correct, and complete. If I become aware that any information in this application is no longer true, correct, or complete, I agree to immediately notify the Mississippi Division of Medicaid in order to update or correct the information.
2. I authorize the Mississippi Division of Medicaid and/or the Medicaid Fiscal Agent to verify the information contained herein. I agree to notify the Mississippi Division of Medicaid of any changes in this form within thirty (30) days of the effective date of the change. I understand that a change in the incorporation or ownership of my organization or my status as an individual or group biller may require a new application.
3. Neither I, as an individual practitioner, nor any owner, director, officer, or employee of the company or other organization on whose behalf I am signing this certification statement, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicaid program or debarred, suspended or excluded under any Federal agency or program, or otherwise prohibited from providing services to Medicaid or other federal health care program beneficiaries.
4. I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicaid to complete or clarify this application may be punishable by criminal, civil, or other administrative actions, as applicable.

SECTION 10 – CERTIFICATION AND SIGNATURES CONTINUED

5. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
6. I understand that the Mississippi Medicaid files will be updated with information supplied on these forms.
7. I give my express consent to the Mississippi Division of Medicaid and/or the Medicaid Fiscal Agent to disclose noted social security number(s) for the sole purpose of verifying eligibility for participation in the Medicaid program to the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies, and other state and federal agencies.
8. I further consent that the Mississippi Division of Medicaid and/or the Medicaid Fiscal Agent may disclose social security number(s) to such appropriate organizations or agencies after this application has been approved so that the Mississippi Division of Medicaid may review the enrolling provider's ability to continue to participate in the Mississippi Medicaid program.

INDIVIDUAL OR SOLE PROPRIETOR SIGNATURE

Individual Applicants

Signature of Individual Enrolling Provider (including suffix)	*Date Signed (MM/DD/YYYY)*

Printed Name

Title (M.D., D.O., etc.)	*First Name*	*MI*	*Last Name (including suffix)*

Sole Proprietor Applicants

Signature of Sole Enrolling Provider (including suffix)	*Date Signed (MM/DD/YYYY)*

Printed Name

Title (M.D., D.O., etc.)	*First Name*	*MI*	*Last Name (including suffix)*

SECTION 10 – CERTIFICATION AND SIGNATURES CONTINUED

AUTHORIZED OFFICIAL SIGNATURE

NOTE: The Authorized Official Signature section must be completed for business applications. Delegated Official Signature is optional.

Authorized Official's Information and Signature

I have read the contents of this application. My signature legally and financially binds **the enrolling provider** to abide by all applicable state and federal law, regulations, policies, and requirements of the Mississippi Division of Medicaid. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Mississippi Division of Medicaid and/or the Medicaid Fiscal Agent to verify this information. If I become aware that any information in this application is no longer true, correct, or complete, I agree to immediately notify the Mississippi Division of Medicaid in order to update or correct the information.

I hereby acknowledge that I have read the Certification Statement listed above and agree to adhere to all of the stated requirements.

Authorized Official Signature (including suffix)	*Date Signed (MM/DD/YYYY)*

Printed Authorized Official Name (First, Middle Initial, Last, Suffix)

Title (M.D., D.O., etc.)	*First Name*	*MI*	*Last Name (including suffix)*

DELEGATED OFFICIAL SIGNATURE (OPTIONAL)

You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make and report changes and/or updates to the provider's status in the Medicaid program.

The signature of a delegated official shall legally and financially bind the provider to the information contained in the provider's enrollment record. By his or her signature, the delegated official certifies that he/she has read the Certification Statement listed above and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When reporting changes and/or updates to the provider's enrollment information maintained by the Medicaid program, the delegated official certifies that the information provided is true, correct, and complete.

Independent contractors are not considered "employed" by the provider and, therefore, cannot be delegated officials.

The signature(s) of an Authorized Official in constitutes a legal delegation of reporting authority to all delegated official(s).

If there are more than two (2) delegated officials, copy and complete this section for each individual.

Delegated Official's Signature

Delegated Official Signature (including suffix)	*Date Signed (MM/DD/YYYY)*

Printed Delegated Official Name (First, Middle Initial, Last, Suffix)

Title (M.D., D.O., etc.)	*First Name*	*MI*	*Last Name (including suffix)*

[ ] Check here if Delegated Official is a W-2 Employee.

Authorized Official's Signature Assigning this Delegation (including suffix)	*Date Signed (MM/DD/YYYY)*

Printed Authorized Official Name (First, Middle Initial, Last, Suffix)

Title (M.D., D.O., etc.)	*First Name*	*MI*	*Last Name (including suffix)*

Division of Medicaid
In the Office of the Governor
Medical Assistance Participation Agreement
(Medicaid – Title XIX Program)
Section C –

***The Medicaid Provider Agrees*:**

1. To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency.

2. To abide by federal and state laws and regulations affecting delivery of services.

3. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services, or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability.

4. To take no action or adopt any procedure that would circumvent or deny freedom of choice to any eligible recipient of medical assistance under the Medicaid program.

5. To refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to an eligible recipient.

6. To make available to appropriate state and federal personnel, during regular business hours, 8:00 a.m. to 5:00 p.m. Monday-Friday, and all other hours when employees of the provider are normally available and conducting the business of the provider in the office of the provider, all records relating to services performed by the Provider including, but not limited to, the following:

   a. Medical records required by Section 1902(a)(27) of Title XIX of the federal Social Security Act and any amendments adopted thereto, Miss. Code Ann. Sections 43-13- 118 and 43-13-121 (4) (1972, as amended), including the implementing of federal and state regulatory requirements.

   b. Documentation in office records regarding services rendered by the Provider in substantiation of its claims for services rendered Medicaid. Documentation must be in accordance with Medicaid policy.

   c. Documentation in office records regarding claims filed with third party sources for Medicaid covered services furnished to eligible recipients which will enable Medicaid to verify that third party policy has been followed. “Documentation” means portions of patient’s file that show third party resource information, evidence of claims filed with third parties and financial records such as accounts receivable listing receipts of third party payments.

7. That in the event the Provider’s license has been revoked by the appropriate Board or if the Provider is disqualified through a federal administrative action, this Agreement is automatically terminated. If the provider is disqualified through state action or Division of Medicaid administrative action, the agreement will terminate upon the effective date of that action.

8. That upon receipt of notification that the Provider is disqualified through any federal, state, an/or Medicaid administrative action, the Provider will not submit claims for payment to the Division of Medicaid for services performed after the disqualification date.

9. To comply with all federal and state standards of practice, including licensure.

   Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children’s Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries. A searchable federal web site, updated monthly, exists at http://exclusions.oig.hhs.gov/.

***The Medicaid Provider Agrees Continued*:**

10. That all Medicaid covered services have been administered and billed in accordance with Medicaid policy.
11. That claims for reimbursement will be submitted in accordance with the instructions from the Division of Medicaid or its designated agent and will conform with the provider billing certification requirements of Medicaid. Provider is responsible for validity and accuracy of claims submitted on paper, electronically or through a billing service.
12. To accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments.
13. To authorize and agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent, the appropriate Direct Deposit Authorization/Agreement Form.
14. To send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Division of Medicaid Agrees:

1. To pay for Medicaid covered services rendered by the Provider in accordance with the fee schedules and/or payment methodologies as prescribed by the Division of Medicaid for reimbursement of such services.
2. To make appropriate disposition as soon as possible of all claims submitted in accordance with the applicable laws and regulations.

The Division of Medicaid and the Provider mutually agree:

1. That payment may be withheld, if necessary, because of irregularity for whatever cause until such irregularity can be adjusted.
2. In the event funds have been overpaid or disallowed, the Provider shall repay within 30 days of discovery by the Provider or notification by the Division or its agent, or on other terms approved by the Division of Medicaid to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a Provider of medical services and legal action by the Division to recover such funds, including the legal rate of interest.
3. In case of institutional providers, when there is a change of ownership of the facility, the new owner, upon consummation of the transaction effecting the change of ownership, 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.
4. That this agreement is subject to availability of state and federal funds, the cessation or reduction of which will constitute the voidance of this Agreement.
5. That this agreement becomes effective in accordance with applicable federal and state law and regulation and Medicaid policy and shall remain in force and effect until terminated by either party as set out herein above.
6. To abide by and to comply with the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the Division of Medicaid or its designated Fiscal Agent, and as may be applicable to the services under this Agreement.
7. That this agreement is not transferable or assignable by the Provider and may be terminated by thirty (30) days written notice by either party, with the exception of paragraph 3 of this section. Changes in ownership, corporate entity, and servicing location shall be reported immediately to the Division of Medicaid.
8. This agreement is automatically terminated in the event Provider's license has been revoked by the appropriate Board, Provider is disqualified through a federal administrative action or Provider is convicted as set forth in Miss. Code Ann. Section 43-13-121 (l) (1972, as amended).
9. That the applicable manual has been or will be furnished to the Provider and is adopted herein as if written in this Agreement.

Provider Name (Type or Print)	
Provider Signature	***Date***
Provider Number	
DOM REP. Signature	***Date***

Instructions for Mississippi Medicaid Provider Disclosure Form (Section C-2)

The Code of Federal Regulations set forth in 42 CFR. §§ 455.100-106 requires that all providers disclose specified information regarding business ownership and control, business transactions, and criminal convictions to the Mississippi Division of Medicaid (DOM). In addition, state law provides that Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These disclosures will be used to determine the applicability of Miss. Code Ann. § 43-13-121(7).

The Provider Disclosure Form is due at any of the following times:

1) Upon submission of a provider enrollment application,
2) Upon change of required disclosing information,
3) Upon request of DOM during revalidation of enrollment, and
4) Within thirty-five (35) days after any change in ownership of provider, and/or upon request by Mississippi Medicaid.

General Instructions

- ✓ Please answer all questions as of the date of submission.
- ✓ Additional pages should be completed as necessary to provide accurate responses.
- ✓ Every question should be answered in an accurate manner and applicable responses provided.
- ✓ Retain a copy for your files.

Definitions

The definitions below are designed to clarify certain questions on the Provider Disclosure Form. These definitions may be found in 42 CFR § 455.101 and the Mississippi Medicaid Admin. Code (Part 200, Rule 4.1), both of which should be consulted for any amendments.

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

B. **Director** is a member of the provider's "board of directors". It does not necessarily include a person who may have the word "director" in his/her job title (e.g. departmental direct, director of operations). Moreover, where a provider has a governing body that does not use the term "board of directors", the members of that governing body will still be considered "directors". Thus, if the provider has a governing body titled "board of trustees" (as opposed to "board of directors"); the individual trustees are considered "directors" for Medicaid enrollment purposes.

C. **Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

D. **Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

E. **Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

F. **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.

G. **Officer** is any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the

board of directors as an officer in accordance with the provider's corporate bylaws.

H. **Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:
   - Any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
   - Any Medicare intermediary or carrier; and
   - Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

I. **Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

J. **Person with an ownership or control interest** means a person or corporation that (a) has an ownership interest totaling five percent or more in a disclosing entity; (b) has an indirect ownership interest equal to five percent or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity; (d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity; (e) is an officer or director of a disclosing entity that is organized as a corporation; or (f) is a partner in a disclosing entity that is organized as a partnership.

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

L. **Subcontractor** means (a) an individual, agency, or organization to which a disclosing entity 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 Medicaid agreement.

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

N. **Termination** means:
   1) For a (i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and (ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
   2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
   3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to (i) fraud, (ii) integrity, or (iii) quality.

O. **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.

The definitions below should be used in answering questions on the Provider Disclosure Form concerning relationships to excluded, penalized, or convicted persons (Section D). These definitions may be found in 42 CFR § 1001.1001, which should be consulted for any amendments.

A. **Agent** means any person who has express or implied authority to obligate or act on behalf of an entity.

B. **Immediate family member** means, a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

C. **Indirect ownership interest** includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)

D. **Member of household** means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

E. **Ownership** interest means an interest in:
   (a) The capital, the stock or the profits of the entity, or
   (b) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

Determination of Ownership or Control Percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. This information may be found in 42 CFR § 455.102, which should be consulted for any amendments.

A. Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation, which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

B. Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Mississippi Medicaid Provider Disclosure Form

This provider disclosure form is for:	
□ Provider Application/Enrollment □ Change of Disclosing Information □ Change of Ownership (CHOW) Date of CHOW: ________________	□ Re-validation □ Request of Division of Medicaid

SECTION A
Disclosing Provider Information

If this form is for an individual, complete this area.			
Last Name (including suffix)	First Name	MI	Title (M.D., D.O., etc.)

If this application is for a group/organization/sole proprietor, complete this area.	
Legal Business Name	
EIN/SSN:	NPI:

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P O Box addresses.)

Address	City	State	Zip	County

If the disclosing entity is an existing MS Medicaid provider, please enter the current Medicaid provider number.	

Type of Business - Privately Owned or Non-profit Providers only	
□ Individual/Sole Proprietorship □ Corporation □ Partnership/Limited Liability Partnership □ Limited Liability Company (LLC)	□ Government Owned □ Non-Profit

SECTION B
Ownership and Control

NOTE: ONLY REPORT ORGANIZATIONS IN THIS SECTION. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity MUST have at least ONE owner and at least one managing employee. If there is more than one business entity with ownership/control interest that should be reported, copy and complete this section for each.

SECTION B-1
Entity with Ownership Interest and/or
Managing Control Identification Information

Check one of the following:

[ ] 5 Percent (5%) or More Ownership Interest [ ] Partner [ ] Managing Control

Effective Date:

Legal Business Name as Reported to the Internal Revenue Service	
Doing Business As Name (if applicable)	Tax Identification Number (required)

Primary Business Address				
Line 1 (Street Name and Number)				
Address Line 2 (Suite, Room, etc.)				
City		State	Zip Code	County
Mailing Address (P.O. Box)	City	State	Zip Code	County

Business Location			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

Business Location			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

Business Location			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

SECTION B-2
Individuals with Ownership Interest and/or Agents/Managing Control

The following individuals must be reported in Section B-2:

- **All individual owners with 5% or more direct/indirect ownership**
- **All officers and directors of the disclosing provider (whether for profit or non-profit)**
- **All managing employees of the disclosing provider**
- **All authorized and delegated officials noted in the Mississippi Medicaid Enrollment application**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this section for each individual.

Last Name	First Name	MI	Suffix

Title (M.D., D.O., etc.)	Social Security Number (required)	Date of Birth (MM/DD/YYYY)	Gender (M/F)

Home Address Line 1

Address Line 2

City	State	Zip Code	County

If the above noted individual is an owner, please select one of the following options and give the effective date:	
[ ] 5 Percent (5%) or Greater Direct/Indirect Owner	[ ] Partner
Effective Date (MM/DD/YYYY):	

If the above noted individual is a managing employee, please select all that apply and give the effective date:			
Title	Effective Date (MM/DD/YYYY)		Effective Date (MM/DD/YYYY)
[ ] Director/Officer		[ ] Managing Employee (W-2)	
[ ] Contracted Managing Employee		[ ] Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:	
[ ] Authorized Official	[ ] Delegated Official
Effective Date (MM/DD/YYYY):	

If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing employee, director, or shareholder and is related to each other as spouse, parent, child, or sibling, please note the name and relationship:	
Name	Relationship

Section C
Criminal Convictions and Other Sanctions

Provide the requested information in this section for any person who:

(1) Has an ownership or control interest in the disclosing provider OR
is an agent or managing employee of the disclosing provider

AND

(2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,

OR

(3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h),
(4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h),
(5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
(6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,
(7) Has had his/her/its license or certification revoked, or
(8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.

Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation.

Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal/Sanction Information	Date
Agency/Court/Administrative Body	Resolution	

Section D
Relationships to Excluded, Penalized, or Convicted Persons in Accordance with 42 CFR § 1002.3

Identify and provide the requested information in this section regarding any person who:

(1) has been convicted of a criminal offense as described in Sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;

(2) has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act; OR

(3) has been excluded from participation in Medicare or any of the state health programs AND

(4) also has one or more of the following relationships to the disclosing provider:

i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;

ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the group/organization or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the group/organization;

iii. is an officer or director of the group/organization, if the group/organization is organized as a corporation;

iv. is a partner in the group/organization, if the group/organization is organized as a partnership;

v. is an agent of the group/organization;

vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the group/organization or part thereof, or directly or indirectly conducts the day-to-day operations of the group/organization or part thereof; or

vii. was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediately family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

NOTE: Please refer to Page 1 of the Instructions for Provider Disclosure Form for applicable definitions.

Name		Relationship	☐ Current ☐ Former
Conviction Information (Crime)			Date of Conviction
Reason for Penalty or Assessment Information			Date Imposed
Reason for Medicare Exclusion Information			Date Imposed
State Health Care Program Exclusion	State Agency and Reason		Date of Exclusion
Name		Relationship	☐ Current ☐ Former
Conviction Information (Crime)			Date of Conviction
Reason for Penalty or Assessment Information			Date Imposed
Reason for Medicare Exclusion Information			Date Imposed
State Health Care Program Exclusion	State Agency and Reason		Date of Exclusion

SECTION E
Disclosure of Other Ownership and Control

Identify individuals or legal entities as having an ownership or control interest who also have an ownership or control interest in any other disclosing group/organization.

Name of the Individual/Legal Entity (noted in Section A or B)
Other Legal Entity Name
Other Legal Entity Address
EIN of the Other:
Are any individuals or legal entities (disclosed in Section B and/or B-2) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to the individual/group/organization (noted in Section C) as a spouse, parent, child or sibling? □ Yes □ No

If yes, please provide the requested information for each:

Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2

SECTION F
Disclosure of Subcontractor Information

Identify any person (individual or legal entity) with an ownership or control interest in any subcontractor in which the disclosing group/organization has a direct or indirect ownership of five percent (5%) or more.

Name of the Individual/Legal Entity (noted in Section A or B)
Name of the Subcontractor

Address of the Subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box addresses.)

Address Line 1			
Address Line 2			
City	State	Zip	County

SSN/EIN of the Subcontractor:
Are any individuals or legal entities (disclosed in Section B-1 and/or 2) as having an ownership or control interest, officer, agent, managing employee, director or shareholder related to the subcontractor (noted in Section D) as spouse, parent, child or sibling? □ Yes □ No

If yes, please provide the requested information for each:

Name	Relationship	Name of Person in Section B-1 and/or B-2

Name	Relationship	Name of Person in Section B-1 and/or B-2
Name	Relationship	Name of Person in Section B-1 and/or B-2

SECTION G **Business Transactions** ***(This section should only be completed at the direction of Division of Medicaid (DOM))***	
Identify the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent (5%) or more. If there are no such transactions to report, please respond "None".	
Name of Subcontractor	
Address	
SSN or EIN	
Name of Owner	Address
Name of Owner	Address
Name of Owner	Address
Identify any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the five-year period before the date of this request below. If there are no significant business transactions to report, please respond "None".	

SECTION H
Attestation and Signature of the Disclosing Provider

I certify that the information on this form, and any submitted statement(s) that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under penalty of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

In addition, I understand that:

- In accordance with 42 CFR § 455.104(e), federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required.
- In accordance with 42 CFR § 455.106(c), DOM may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under 42 CFR § 455.106(a).
- In accordance with Miss. Code Ann. § 43-13-121, Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These circumstances include failure to truthfully or fully disclose any and all information required on this form, or making a false or misleading statement to DOM relative to the Medicaid program.
- In accordance with 42 CFR § 455.436, the State Medicaid agency and all Medicaid contractors shall do the following:
  1. Confirm the identity and determine the exclusion status of providers and contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider or contractor/subcontractor through routine checks of federal databases; and,
  2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, credentialing, or re-credentialing, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

NOTE: If the disclosing provider is an individual or a sole proprietor, the application must be signed by the individual provider or sole proprietor.

If the disclosing provider is a group/organization, the signature should be that of the person legally authorized to sign on behalf of the group/organization.

Printed Last Name (*including suffix)*:	Printed First Name	MI
Signature:		
Title:	Date:	

Civil Rights Compliance Information Request Package
Section C – 3 (Pages 1-13)

The Office of the Governor, Division of Medicaid, is responsible for enforcing several civil rights laws as they apply to applicants and/or recipients of federal financial assistance from the United States Department of Health and Human Services (US DHHS). These laws prohibit discrimination based on race, color, national origin, age, disability, limited English Proficiency, and in some instances, sex and religion.

As part of the application process for a Mississippi Medicaid Provider, you must be evaluated for compliance with the civil rights laws as described above. In order to determine your eligibility to participate in federally financed programs, please provide the information identified in the enclosed Civil Rights Compliance Information Request Package.

If you have received a Medicare certification approval letter, a copy of the compliance letter (Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discriminations Act of 1975 and Section 1557 of the Affordable Care Act of 2010) may be submitted in lieu of completing DOM's compliance packet. Medicare compliance mirrors the Medicaid compliance review requirements, as both programs are recipients of federal financial assistance and are monitored by the Office of Civil Rights for non-discrimination.

For any assistance in completing this information, please contact the Office of Provider Enrollment at 1-800-421-2408.

Thank you for your cooperation.

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

In order for a provider/vendor to participate as a provider of services in the Medicaid program, it must meet certain requirements. One such requirement is to ensure that qualified persons are not denied benefits or services based on race, color, national origin, disability, or age. In accordance with the Centers for Medicare and Medicaid Services (CMS) and civil rights regulations, it is the responsibility of the Office of the Governor, Division of Medicaid (DOM) to conduct a review of such a provider to determine its compliance with the requirements of Title VI of the Civil Rights Act of 1964 (race, color, national origin or Limited English Proficiency), Section 504 of the Rehabilitation Act of 1973 (disability), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act of 2010.

In order for DOM to determine compliance with the above requirements, please respond to this Civil Rights Compliance Information Request. To assist in providing this information, technical assistance materials have been included which may be helpful.

In determining a provider's compliance with the civil rights authorities cited above, DOM will evaluate the materials provided in response to the information request, which will allow DOM to examine compliance in the areas of:

- Nondiscrimination policies and the manner of their dissemination;
- Communication with persons who have a sensory or speech impairment;
- Communication with persons who have Limited English Proficiency;
- Provision of required notices and manner of providing notice;
- Section 504 coordination; and
- Restrictions based on age.

Based on your response to the information request, DOM staff will determine the need for additional information, which may be obtained through a written request, telephone contact, or site review.

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

In completing the attached Civil Rights Compliance application, below is a list of the required documentation that must be returned to the Division of Medicaid.

- General Data about the provider/Vendor (signature required) - Page 4 and 5
- A copy of the provider's Nondiscrimination Policy - See example on Page 7
- A copy of the provider's Limited English Proficiency Policy – See example on Page 11
- A copy of the provider's Sensory and Speech Impairment Policy – See example on Page 10
- A copy of provider's Program – Facility Accessibility Policy – See example on Page 12
- Statement of Compliance (signature required) – Page 13
- Attach a copy of the provider's most current published Newspaper article stating the provider's Nondiscrimination policy **(for LTC Facilities ONLY)**

OR

- General Data about the provider/Vendor (signature required) - Page 4 and 5
- Attach a copy of the provider's most recent published Newspaper article stating the provider's Nondiscrimination policy **(for LTC Facilities ONLY)**
- DHHS – Office Of Civil Rights letter of compliance

Civil Rights Compliance Information Request for Medicaid Certification

Please return your response to this information request with your provider enrollment application.

Note: Please submit all data for numbers 1 through 7.

1. General data about the provider/vendor	
A. Name of provider/vendor	
B. Address	
C. Administrator's Name	
D. Contact Person's Name (If different form Administrator)	
E. Phone Number	***F. TDD***
G. Email	***H. FAX***
I. NPI	***J. Tax ID/SSN***
Type of provider/vendor (physician, dentist etc.)	
Number of employees (including part time)	

2. A signed copy of the form, Statement of Compliance (included). (A copy should be kept by provider/vendor and a signed original must be returned with your response to information request.)

3. Data regarding your nondiscrimination policies and notices, including: (*Please see Attachment A "Establishing Effective Nondiscrimination Policies and Notice Procedures," for help in creating or modifying a nondiscrimination policy.)*

A. A copy of your written notice(s) of nondiscrimination that provides for admission and services without regard to race, color, national origin, disability, or age.

B. A description of the methods used by the provider/vendor to disseminate its nondiscrimination notice(s) to participants, beneficiaries, and potential beneficiaries, employees, patients, community organizations, and referral sources of the protection against discrimination assured them by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act of 2010. *(Please submit copies of brochures or newspaper articles, if publication is one of the methods used.)* Please describe methods used to provide this information to persons who have sensory impairments and to persons who have Limited English Proficiency (LEP).

4. Data regarding your staff's communication with persons of national origin who are LEP, including: (Please see Attachment B, "How to Establish Effective Communication Procedures for Persons with Limited English Proficiency and for Persons with Impaired Hearing, Vision, or Speech," for help, if needed.)

A. A description (or copy) of procedures used by provider/vendor to communicate with persons who have LEP, including how you obtain qualified interpreters for such persons.

B. Samples of all written material printed in a non-English language. (Notices, consent forms, waivers, description of services provided, explanation of procedures, etc). If none is available, a description of how LEP beneficiaries are provided the same information as other beneficiaries.

5. Procedures used by a provider/vendor to disseminate information to patients and potential patients about the existence and location of your services and facilities that are accessible to persons with disabilities. (Please see Attachment C.)

General data about the provider/vendor continued:

6. Data regarding the available auxiliary aids which a provider/vendor provides to persons with impaired sensory, manual, or speaking skills: *(Please see Attachment C, "504 Notice of Program Accessibility," for examples of auxiliary aids.)*

A. If a provider/vendor employs 15 or more persons, please contact DOM regarding other requirements under DOM's Section 504 regulations for providers with 15 or more employees.

B. If a provider/vendor employs fewer than 15 persons, a provider/vendor has a continuing obligation to ensure that qualified persons with disabilities are not denied services because of their disability. To meet this obligation, a provider/vendor should, on its initiative, examine the needs of sensory and speech-impaired patients/clients and potential patients/clients. Based on the needs identified, such auxiliary aids can be made readily available. DOM regulations do not specifically require a provider/vendor to furnish auxiliary aids if the provision of such aids would significantly impair a provider/vendor's ability to provide benefits and services.

7. Data regarding Age Discrimination Act, including a description or copy of any policy(ies) or practice(s) restricting or limiting admissions or services provided by a provider/vendor on the basis of age.

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided to facilitate prompt processing of a provider/vendor's request for Medicaid participation. Failure to provide the information/data requested may delay provider/vendor's certification for funding.

CERTIFICATION:

I certify that the information provided to the DOM is true and correct to the best of my knowledge

Provider Signature	***Date***

Provider's Title

ATTACHMENT A

ESTABLISHING EFFECTIVE NONDISCRIMINATION POLICIES AND NOTICE PROCEDURES

Various sections of the regulations implementing Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975 and Section 1557 of the Affordable Care Act of 2010, *require providers that are "recipients" of Federal financial assistance to notify beneficiaries, potential beneficiaries, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, sex, disability, Limited English Proficiency, or age. For notice to be effective, an appropriate policy statement of nondiscrimination must be adopted and disseminated.* (see Part II)

To meet these requirements, many providers elect to adopt a single policy of nondiscrimination on the basis of race, color, national origin, sex, disability, or age in the provision of services and employment. Additional nondiscrimination factors, such as sex, religion or creed, methods of payment, etc., are sometimes added to meet other federal, state, or local requirements. (A model nondiscrimination policy statement is attached.)

Once adopted, the notice must be distributed to the general public and such protected groups as sensory impaired persons and those with Limited English Proficiency. "Effective Notice" does not mean that every individual within a particular group must be notified or that all publications must be translated into languages represented in the service area population. Nor does it specifically require an outreach program. It usually means, however, that the provider must take extra steps to ensure that persons protected by the regulations have an equal opportunity to receive notice of and access to its programs.

(PART I) STEPS IN DEVELOPING AN EFFECTIVE NOTICE PROCEDURE

An effective procedure can usually be developed by taking the following steps: (The specific procedure will necessarily reflect the kinds of information normally distributed by the provider, community resources available, and input from those resources.)

1. Identify the existing methods of distributing information on services, benefits, waivers of rights and consent to treatment to beneficiaries, potential beneficiaries, applicants and employees.
2. Familiarize yourself with your service area by identifying the major languages and disabled groups. This can be done by gathering statistical data from such sources as the U.S. Census, local and state planning bodies, chambers of commerce, educational institutions, and other providers.
3. Determine if the existing methods of giving notice adequately reach persons with limited proficiency in English and persons with impaired vision or hearing.
4. Consult with members of these groups or with organizations representing them for suggestions about ways to give notice to their constituencies, such as at regular meetings and conferences, through newsletters or other publications, and by posting in the provider/vendor’s office and locations frequented by the particular group.
    - For persons whose primary or exclusive language is other than English, translated versions of the notices and bilingual interpreters should be available. For persons who are sensory or speech impaired, braille versions, voice tapes, interpreters, or readers should be available depending upon the circumstances. The persons and groups receiving the notice are usually the best guides for determining the most effective methods.
5. Describe how the notices will be disseminated to Limited English Proficient speaking persons end to persons with sensory or speech impairments. This usually means adopting an instruction or standard operating procedure.
6. Notify and train appropriate staff about the notice procedure.

(PART II)
NOTICE REQUIREMENTS AND REGULATION CITATIONS

TITLE VI

Notify participants, beneficiaries, and other interested persons of the provisions of the Title VI Regulation and how it applies to the recipient's program - 45 C.F.R. § 80.6(d);

Notify all persons concerning their right to file a complaint of discrimination and the procedure for filing such a complaint - **45 C.F.R. § 80.6(d).**

SECTION 504

- Adopt and implement procedures to ensure that interested persons, including those with impaired vision or hearing, can obtain information about the recipient's facilities which are accessible to and usable by disabled persons - **45 C.F.R. § 84.22(f);**
- Notify disabled persons, including those with sensory or speech impairments, of any general notices of the recipient's services or benefits and of written materials concerning waivers of rights or consent to treatment (e.g., information releases, financial agreements, insurance assignments, informed consent for treatment) - **45 C.F.R. § 84.52(b)**;
- Notify participants, beneficiaries, applicants, employees, and affiliated unions or professional organizations that the recipient does not discriminate on the basis of disability in violation of Section 504 in the areas of access, admission, treatment, or employment - **45 C.F.R. § 84.8(a);**
    - Include in the notice the name or title of the employee designated by the recipient to be responsible for coordinating its efforts to comply with Section 504;
    - Ensure that persons with impaired vision or hearing receive effective notice of the foregoing;
- Include the nondiscrimination notice in publications of general information about the recipient's programs by adding appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications - **45 C.F.R. § 84.8(b).**

AGE DISCRIMINATION ACT

Notify program beneficiaries of the protection against discrimination on the basis of age provided by the Act and its regulations - **45 C.F.R. § 91.32(b).** ************************

SECTION 1557

- Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities under TVI, Title IX, the Age Discrimination Act and Section 504 of the Rehabilitation Act. **45 C.F.R. § 92.1.**
- Provide meaningful access to an individual with limited English proficiency that is served or encountered in its health programs and activities. The covered entity must offer that individual a qualified interpreter and translation services. **45 C.F.R. § 92.201(a).**

(Attached are examples of a nondiscrimination policy and a nondiscrimination statement which, if properly completed, are suitable for posting and other dissemination.)

The following is an example of a nondiscrimination policy suitable for posting and other dissemination.

NONDISCRIMINATION POLICY

As a recipient of federal financial assistance, the ***(name of provider***) does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, sex, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by ***(name of provider***) directly or through a contractor or any other entity with whom the ***(name of provider***) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act of 2010, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, 91, and 92. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)

In case of questions concerning this policy, or in the event of a desire to file a complaint alleging violations of the above, please contact:

Provider Name

Coordinator
Telephone number
TDD

The following is a notice of nondiscrimination which was found to be acceptable as a shortened version of a provider's adopted policy of nondiscrimination. Owing to its brevity, such a statement is more convenient to include in publications, announcements, advertisements, etc., than the complete policy.

(***Name of provider***) does not discriminate against any person on the basis of race, color, national origin, sex, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: ***(name, phone number, TDD).***

ATTACHMENT B

HOW TO ESTABLISH EFFECTIVE COMMUNICATION PROCEDURES FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY AND FOR PERSONS WITH IMPAIRED HEARING, VISION, OR SPEECH

The Department of Health and Human Services has issued regulations to notify health care and social service providers, who are recipients of federal financial assistance from the Department, of their civil rights obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act of 2010. Regulations or Title 45, Code of Federal Regulations Part 80, issued pursuant to Title VI, prohibit recipients from conducting any program, activity or service in a manner that excludes, denies, or otherwise discriminates on the basis of race, color, or national origin. Regulations or Title 45, Code of Federal Regulations Part 84, issued pursuant to Section 504, prohibit similar discrimination on the basis of disability. Regulations or Title 45, Code of Federal Regulations Part 92.101, prohibit covered entities from discriminating on the basis of color, national origin, sex, age, or disability. Health care and social service providers may also be subject to Title II or Title III of the Americans with Disabilities Act (ADA). Title II of the ADA prohibits discrimination against individuals with a disability in public services, and Title III of the ADA prohibits discrimination in public accommodations against individuals with a disability.

A frequent cause of discrimination on the basis of national origin in a health care setting that may violate Title VI is a provider's method of communicating with patients and other persons who, because of their national origin, have limited proficiency in speaking or understanding English. A similar cause of disability discrimination is a provider's ineffective communication with patients and other persons who have sensory or speech impairments.

Providers have an obligation under 45 C.F.R. Part 80 to ensure that persons with limited proficiency in English, because of their national origin, have a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered. Under 45 C.F.R. Part 84, for providers with 15 or more employees, individuals with sensory or speech impairments must have an opportunity equal to, or as effective as, that afforded others to apply for, receive or participate in, or benefit from the services offered. One way for providers to meet these obligations is to establish written procedures (sample written procedures are included) and train staff on how to obtain assistance in communicating with patients who are Limited English Proficient (LEP), and who have sensory or speech impairments.

Providers have the obligation to provide communication aids and qualified interpreters at no cost to the LEP/sensory impaired person.

The following is a sample procedure for effective communication with persons with sensory impairments.

PROCEDURE FOR COMMUNICATING INFORMATION TO PERSONS WITH SENSORY IMPAIRMENTS

(Name of provider) will take such steps as are necessary to ensure that qualified persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice concerning benefits or services or written material concerning waivers of rights or consent to treatment. All aids needed to provide this notice are provided without cost to the person being served.

For Persons With Hearing Impairments: Qualified sign-language interpreter for persons who are deaf/hearing impaired and who use sign-language as their primary means of communication, the following procedure has been developed and resources identified for obtaining the services of a qualified sign-language interpreter to communicate both verbal and written information:

(Insert the information for obtaining the services of a qualified sign-language interpreter. The information should identify the staff person authorized to obtain the interpreter, the information on the agency that has agreed to provide the service, telephone numbers and hours of availability and/or a list of qualified staff interpreters. Methods used to train patient contact staff in the use of effective methods of communication with Sensory Impaired persons should also be included. Note: Family members and friends should be used as interpreters only if: 1) the patient/client has been made aware of the availability of qualified sign-language interpreters at no additional charge and, without any coercion whatsoever, chooses the services of family members or friends). 2) If no interpreters are available in your community (within 30 miles of provider/vendor).

If your agency/provider/vendor utilizes a Telecommunication Device for the Deaf (TDD), give an explanation of where it is located, how to operate it, and the telephone number. If there is an arrangement for sharing a TDD, give an explanation of the sharing arrangement, the telephone number and the procedures for borrowing the device.

For Persons With Visual Impairments: Reader/staff will communicate the content of written materials concerning benefits, services, waivers of rights, and consent to treatment forms by reading them out loud to visually impaired persons.

Large print, taped, and braille materials: (If any of these aids are chosen, in addition to reading, this section should tell what other aids are available, where they are located, and how they are used.)

For Persons With Speech Impairments: Writing materials, typewriters, TDD, and computers are available to facilitate communication concerning program services and benefits, waivers of rights, and consent to treatment forms.

The following is a sample procedure for effective communication with persons of Limited English Proficiency.

PROCEDURE FOR COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY

POLICY:

It is the policy of **(name of provider)** to provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons, including current and prospective patients, clients, family members, interested persons, et al., to ensure them a meaningful opportunity to apply for, receive or participate in, or benefit from the services offered. The procedures outlined below will reasonably ensure that information about services, benefits, consent forms, waivers of rights, financial obligations, etc., is communicated to LEP persons in a language which they understand. Also, they will provide for an effective exchange of information between staff/employees and patients/clients and/or families while services are being provided.

PROCEDURE:

1. The **(provider)** will designate **(employee name and/or title)** to be responsible for implementing methods of effective communication with LEP persons.

2. **(Employee name and/or title)** will:

   - Maintain and routinely update a list of all bilingual persons, organizations, and staff members who are available to provide bilingual services, and

   - Develop written instructions on how to gain access to these services, i.e., contact persons, telephone numbers, addresses, languages available, hours available, fees and conditions under which the person(s) are available.
     - Post a short “tagline” written in at least the top 15 languages spoken by individuals with limited English Proficiency in relative state informing that language assistance service is free of charge.

3. In order to ensure effective communication and to protect the confidentiality of (client/patient) information and privacy, the **(client/patient)** will be informed that the services of a qualified interpreter are available to him/her at no additional charge. Only after having been so informed, the **(client/patient)** may choose to rely on a family member or friend in an emergency situation. The choice of the **(client/patient)** and presence of an interpreter will be documented after every visit.
     - Use a translator when translating written content in paper or electronic form.

ATTACHMENT C

SECTION 504 NOTICE OF PROGRAM ACCESSIBILITY

The regulation implementing Section 504 requires that an agency/provider/vendor *"shall adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons."* (45 C.F.R. §84.22(f))

The following Access Notice examples meet regulatory requirements for notice to those persons able to read English printed in this format.

Access Notice (Example)

This provider/vendor and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level with elevator access to all other floors.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards.
- A full range of assistive and communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids:

If you require any of the aids listed above, please let the receptionist or your nurse know.

Civil Rights Compliance Information Request for Medicaid Certification	

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b). the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, Section 1557 of the Affordable Care Act of 2010 (45 U.S.C. 92.101), and the Regulations issued there under by the Department of Health and Human Services (42 CFR Parts 80, 84 and 90) no individual shall, on the grounds of race, sex, color, creed, national origin, limited English proficiency age or handicap, be excluded from participation, be denied the benefits of, or be otherwise subjected to discrimination under any program or services of this institution.

Provider's Acknowledgement
I certify that all responses and information give are trued to the best of my knowledge.
Print Name
Provider's Signature
Date

Facility Operations Contact Person:
Print Name and Title as stated by Employer
Phone Number
Signature
Date

DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

(Page 1 of 4)

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would otherwise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically. **Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.**

You may contact Mississippi's Provider Relations Unit at 1-800-884-3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

Attention! It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name* ____________________

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)* **or** Employer Identification Number (EIN) [| | | | | | | |]

National Provider Identifier (NPI)* [| | | | | | | | |]

Provider Contact Information

Provider Contact Name ____________________

Title ____________________

Telephone Number [| | | | | | | | |] Telephone Number Extension ____________________

Email address ____________________

Fax Number ____________________

Financial Institution Information

Financial Institution Name* ____________________

Financial Institution Address

Street	City	State	Zip

Financial Institution Routing Number* [| | | | | | | |]

DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Type of Account at Financial Institution* — O Checking / O Savings

Provider's Account Number with Financial Institution* — [ ]

Account Number Linkage to Provider Identifier* (**Must Match ERA Preference**) — O Provider Tax Identification Number (EIN/TIN) / O National Provider Identification Number (NPI)

Submission Information

Reason for Submission* — O New Enrollment / O Change Enrollment / O Cancel Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Division of Medicaid to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Division of Medicaid in order to change my bank account information immediately. I will not hold the Mississippi Division of Medicaid liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Written Signature of Person Submitting Enrollment*

[ ]

Printed Name of Person Submitting Enrollment

[ ]

Submission Date

[ ]

DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number in the TIN/EIN field.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number. If you are a Non-Healthcare Provider without an NPI, enter 10 zeros in the NPI field.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title - Enter the title of the Provider Contact person.

Telephone Number - Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension - Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address - Enter the email address of the Provider Contact Person.

Fax Number - Enter the fax number of the Provider Contact Person.

Financial Institution Information

Financial Institution Name* - Enter the name of the financial institution that is to receive the provider's payments.

Financial Institution Address (Street) - Enter the street address of the financial institution.

Financial Institution Address (City) - Enter the city address of the financial institution.

Financial Institution Address (State) - Enter the two digit state abbreviation of the financial institution.

Financial Institution Address (Zip) - Enter the zip code address of the financial institution.

Financial Institution Routing Number* - Enter the nine digit routing number of the financial institution.

Type of Account at Financial Institution* - Check the Checking radio button if the account at the financial institution is a checking account. Check the Savings radio button if the account is a savings account.

Provider's Account Number with Financial Institution* - Enter the provider's account number with the financial institution.

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is a Non-Healthcare Provider and does not have an NPI, enter 10 zeros in the NPI field.

DIRECT DEPOSIT AUTHORIZATION / AGREEMENT FORM

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for EFT. Check the Change Enrollment radio button if this application is to make a change to an existing provider's EFT information. If the Cancel Enrollment radio button is checked, the cancellation will be denied since an EFT is required to be on file for all active providers.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the individual provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

Missing or Late EFT Procedures

- The provider will contact the Conduent Call Center at (1-800-884-3222) to verify their banking information that is currently on file.
- The Call Center Agent will verify the banking account and routing numbers.
- If the account number is correct, the Call Center Agent will advise the provider to contact their financial institution's ACH department.
- If the banking account or routing number isn't correct, the Call Center Agent will direct the provider to update their banking account information via this Direct Deposit Authorization/Agreement form which is available on the Mississippi Medicaid website at www.ms-medicaid.com under Provider →Provider Enrollment for online submission to be downloaded.

Instructions for W-9 Taxpayer Identification Number Request (C-5)

Group/Organization and Sole Proprietor Applicants:
The name on the W-9 should match the written confirmation from the IRS confirming your Tax Identification Number with the legal business name/legal name as noted in Section 1 of the Mississippi Medicaid Provider Enrollment Application.

Individual Applicants
The name on the W-9 should match the legal name as noted in Section 1 of the Mississippi Medicaid Provider Enrollment Application.

Form **W-9**
(Rev. December 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ________

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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 instructions for line 1 and 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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

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

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

• Form 1099-INT (interest earned or paid)

• Form 1099-DIV (dividends, including those from stocks or mutual funds)

• Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)

• Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)

• Form 1099-S (proceeds from real estate transactions)

• Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

• An individual who is a U.S. citizen or U.S. resident alien;

• A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;

• An estate (other than a foreign estate); or

• A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

• In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;

• In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and

• In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (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 payee 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, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, 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,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

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

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 *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

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

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. 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 line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the “Limited Liability Company” box and enter “P” in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the “Limited Liability Company” box and in the space provided enter “C” for C corporation or “S” for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the “Limited Liability Company” box; instead check the first box in line 3 “Individual/sole proprietor or single-member LLC.”

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

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 U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

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

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

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

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

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with “Not Applicable” (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

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-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a corporation or partnership, 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 SSA office or get this form online at *www.ssa.gov*. 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 Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting 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, apply for a TIN and 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. Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. 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, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 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 made in settlement of payment card and third party network transactions, 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 disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. 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
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[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 "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the 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.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

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.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and 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. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Mississippi Medicaid CLIA Certification Information
Section D – 1 (Page 1 of 1)

General Instructions: Please complete this form. If more than one CLIA number is used, each number must be listed. Forms that are illegible/incomplete will be returned.

Please indicate whether you WILL or WILL NOT Bill for lab services. If you WILL NOT Bill for lab services, please sign on the first signature below, do not complete any other part of this form and return with your provider application.
If you WILL Bill for lab services, please complete this form and return with your provider application.

☐ I WILL Bill for Lab Services ☐ I WILL NOT Bill for Lab Services

Provider Name	***Provider Contact***
Provider Number	***Provider Telephone Number***

Provider's Address (City, State and Zip Code)

CLIA Certification Number

Address of Lab

Signature - (Signature Stamps are NOT Acceptable)	***Date***

If the CLIA number is not issued to the person/entity indicated above, please provide below a signature from the provider to whom the CLIA number is issued and who authorizes your use of the laboratory location and corresponding CLIA number.

Signature

I have authorized the above provider to use the laboratory facilities associated with my CLIA number and therefore, to bill claims to Medicaid using my CLIA number.
Please legibly print the name of the person who has legal authority for the CLIA number/location in the space below.

Name

Address

Phone Number

Signature – Signature Stamps are NOT Acceptable	***Date***

A COPY OF THE CLIA CERTIFICATE MUST BE ATTACHED – If the CLIA certificate is not available, attach a copy of the documentation which substantiates the CLIA number.

EDI Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Please complete the following Mississippi Medicaid Provider EDI Enrollment Packet. The package consists of the Conduent EDI Provider Enrollment Form, Mississippi EDI Provider Agreement and the Conduent EDI Gateway Inc., Trading Partner Agreement. Once the package has been completed and signed please return it to the address above for processing. If you have any questions about the Conduent EDI Provider Enrolment Form or EDI Trading Partner Agreement, contact the EDI Support Unit at 1-866-225-2502, Monday-Friday 8AM-5PM CST.

Attention!! Effective January 1, 2014, providers will need to submit a separate ERA Enrollment Form for 835 transactions. This form is available for download or online submission on the MS Medicaid Web Portal at www.ms-medicaid.com.

Please print or type. Complete all areas of Agreement and Enrollment form, unless otherwise indicated.

EDI PROVIDER ENROLLMENT FORM

Section 1 Application Type- Please select all that apply

☐ New Submitter (I would like to become a trading partner with Conduent EDI to submit my claims such as 837.)

☐ New Retriever (I would like to become a trading partner with Conduent EDI to retrieve my responses such as 277.)

☐ Change/Correction (I am a current trading partner with Conduent, I would like to update my current trading partner profile.)

☐ Billing Agent/Clearinghouse Authorization (I am a provider who will allow a billing agent/clearinghouse to submit and/or retrieve transactions on my behalf.)

Section 2 Provider Information

Provider/Business Name	
Street Address	
City, State, Zip Code	
Telephone	*Fax*
Pay-to Provider Number	
EIN (Required if your pay-to number is registered as a group provider number with Mississippi Medicaid.) ☐☐ - ☐☐☐☐☐☐☐	
Email Address	

Section 3 Submitter/Trading Partner ID Number

If you are currently submitting electronic transactions directly to Conduent EDI Gateway, Inc., please indicate your Conduent EDI Gateway Submitter/Trading Partner ID. (This section is required if you have chosen application type “change/correction” in section 1.)

EDI Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Section 4 Individual Contact Information- Please indicate contact if different from Provider Information in Section 2 (Attach additional sheets if necessary)

Contact Name	*Contact Title*
Street Address	
City, State, Zip Code	
Telephone	*Fax*
Email address	

Section 5 Submission Method- Please indicate how you plan to submit your electronic transactions to Medicaid.

- ☐ Vendor Software (If you select this option then you are required to complete sections 6 and 11.)
- ☐ WINASAP5010 (If you select this option then you are required to complete section 10)
- ☐ Web Portal (If you select this option then you are required to complete section 12.)
- ☐ I plan to develop my own software (If you select this option then you are required to complete sections 7 and 11.)
- ☐ I plan to use a Billing Agent/Clearinghouse (If you select this option then you are required to complete sections 8 and 11.)

Section 6 Software Vendor Information – If you have indicated that you plan to use the services of a Software Vendor to submit your transactions electronically to Conduent EDI Gateway, please provide the following information regarding your agent. Your Software Vendor is required to enroll and receive their own unique trading partner ID to test with Conduent EDI Gateway. Please indicate your Software Vendor's Conduent EDI Gateway trading partner ID. Please contact your Software Vendor for this required information.

Software Vendor Company Name	
Contact Name	*Contact Title*
Telephone	*Fax*
Email Address	*Software Vendor's Conduent EDI Gateway Trading Partner ID (required)*

EDI Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Section 7 I plan to develop my own software - If you plan to develop your own software, you must test your software with Conduent EDI Gateway. Please provide the following information.

Software Name	Software Version	Protocol

Section 8 Billing Agent/Clearinghouse Information - If you have indicated that you plan to allow a Billing Agent/Clearinghouse to submit and/or retrieve transactions electronically with Conduent EDI Gateway on your behalf, please provide the following information regarding your agent. Your Billing Agent/Clearinghouse is required to enroll and receive their own unique trading partner ID to test and transmit with Conduent EDI Gateway. Please indicate your agent's Conduent EDI Gateway trading partner ID. Please contact your agent for the required information.

Billing Agent/Clearinghouse Company Name	
Contact Name	*Contact Title*
Telephone	*Fax*
Email Address	*Billing Agent/Clearinghouse Conduent EDI Gateway Trading Partner ID (required)* ☐ ☐ ☐ ☐ ☐ ☐

Section 9 Delimiter Information - If you are submitting X12N transactions, please provide the following. (If nothing is entered the default delimiter will be used). (Note: Providers may need to contact their third-party vendor for this information.)

Element Delimiter to be used:	*Segment Delimiter to be used:*	*Sub-Element Delimiter to be used:*
Default Delimiter (asterisk) *	*Default Delimiter (tilde)* ~	*Default Delimiter (colon)* :

Section 10 Transactions - WINASAP5010

Request for Software

☐ I will download the WINASAP5010 Software. (www.ms-medicaid.com)

☐ Please mail me a CD-ROM of the software.

X12N 837P (Professional Claim)	☐	X12N 837I (Institutional Claim)	☐
X12N 837D (Dental Claim)	☐		

EDI Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Section 11 Transactions - Other than WINASAP5010			
X12N 837P (Professional Claim)	☐	X12N 270 (Eligibility Inquiry)	☐
X12N 837D (Dental Claim)	☐	X12N 276 (Claim Status Inquiry)	☐
X12N 837I (Institutional Claim)	☐	X12N 278 (Prior Authorization)	☐

Section 12 Web Transactions			
X12N 837P (Professional Claim-batch only))	☐	X12N 270 (Eligibility Inquiry- batch only)	☐
X12N 837D (Dental Claim-batch only)	☐	X12N 276 (Claim Status Inquiry- batch only)	☐
X12N 837I (Institutional Claim- batch only)	☐	X12N 278 (Prior Authorization- batch only)	☐

Section 13 Electronic Response and Report Retrieval for Provider			
Are you interested in retrieving your reports and/or responses electronically? **Yes** ☐ **No** ☐			
If yes, please fill out the appropriate sections below			
Reports Available via Conduent EDI Gateway iDex (Internet Data Exchange) http://edionline.acs-inc.com/			
271 - Eligibility Response	☐	997 - Functional Acknowledgement (X12N submissions only)	☐
278 - Prior Authorization Response	☐	277 - Claims Status Response	☐
820 - Premium Payment	☐	824 - Error Report	☐

Section 14 Electronic Response and Report Retrieval for Billing Agent or Clearinghouse			
Do you authorize your Billing Agent/Clearinghouse to retrieve your response and/or reports electronically on your behalf? Yes ☐ **No** ☐			
If yes, please fill out the appropriate sections below			
Billing Agent/Clearinghouse Company Name (required)		*Billing Agent/Clearinghouse Conduent EDI Gateway Trading Partner ID (required)* ☐☐☐☐☐☐	
271 - Eligibility Response	☐	997 - Functional Acknowledgement (X12N submissions only)	☐
278 - Prior Authorization Response	☐	277 - Claims Status Response	☐
820 - Premium Payment	☐	824 - Error Report	☐

	EDI Provider Agreement and Enrollment Form **Please return to:** **Mississippi Medicaid Program** Provider Enrollment P.O. Box 23078 Jackson, Mississippi 39225

Section 15 Web Portal (Note: You will not be able to receive an X12 response unless you submitted an X12 transaction)

☐ I will retrieve my reports from the web. (Note: Only available if transactions were submitted through the web portal- see Section 12)

Reports Available via Web Portal www.ms-medicaid.com			
271 - Eligibility Response	☐	824 - Error Report	☐
278 - Prior Authorization Response	☐	997 - Functional Acknowledgement (X12N submissions only)	☐
820 - Premium Payment	☐	277 - Claims Status Response	☐

EDI Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

The following constitutes an Electronic Data Interchange Agreement ("EDI Agreement") between the Health Care Provider listed in Section II ("Provider") and the Mississippi Division of Medicaid ("DOM") or its designated Fiscal Agent. This EDI Agreement defines the requirements for Electronic Data Interchange between the Provider and the DOM or its designated Fiscal Agent. Any references in this EDI Agreement to the submission of electronic transactions, refers to electronically submitted transactions as chosen by the Provider.

Section I - Terms of Agreement
The Provider agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the DOM or its designated Fiscal Agent.

The Provider agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Provider agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Provider agrees that if a Billing Agency or Clearinghouse is used for the submission of electronic transactions, the Billing Agency or Clearinghouse identified in Section III must have a Trading Partner Service Agreement on file with the DOM or its designated Fiscal Agent.

If using a Billing Agency or Clearinghouse, the Provider agrees to report information accurately and completely to the Billing Agency or Clearinghouse as required in the Appropriate DOM Electronic Transactions Submission Manual and agrees to be completely responsible for the electronic transactions generated from the information submitted to the DOM or its Fiscal Agent by the Billing Agency or Clearinghouse.

If using a Billing Agency or Clearinghouse, the Provider agrees to not use any Billing Agency or Clearinghouse except the one listed in Section III of this agreement until this EDI Agreement has been terminated in writing to the DOM or its designated Fiscal Agent.

If using an EDI software vendor for submission of electronic transactions, the Provider agrees to insure that all data meets the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

If any information supplied in this EDI Agreement changes at any time during the Provider's enrollment in the Mississippi Medicaid program, the Provider agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this EDI Agreement.

Whenever necessary, this EDI Agreement may be amended by mutual consent of the DOM and the Provider to meet federal or other operational requirements.

The Provider agrees that the EDI Submitter ID is confidential and is not transferable or assignable.
This EDI Agreement is not transferable or assignable and may be terminated on thirty (30) days written notice by either party.

This EDI Agreement is automatically terminated in the event the Provider's license is revoked by the Appropriate Board, the Provider is disqualified through a federal administrative action, or as set forth in Miss. Code Ann. Section 43-13-121(l) (1972, as amended).

Authorization

I certify that all statements made herein are true and complete to the best of my knowledge.	
Authorized Signature	Date

Conduent EDI Gateway, Inc. Provider Agreement

Please return to:

Mississippi Medicaid Program

Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

CONDUENT EDI GATEWAY, INC.
TRADING PARTNER AGREEMENT

THIS TRADING PARTNER AGREEMENT (“Agreement”) is by and between **TRADING PARTNER** (“Trading Partner”) and CONDUENT EDI GATEWAY INC. (“EDI Gateway”) collectively “the parties”.

WHEREAS, Trading Partner desires to transmit Transactions to EDI Gateway for the purpose of submitting data to a Health Plan;

WHEREAS, EDI Gateway desires to receive such transactions for this purpose recognizing the EDI Gateway performs such services on behalf of the Health Plan; and

WHEREAS, Trading Partner is subject to the Transaction and Code Set Regulations with respect to the transmission of such transactions.

Now, therefore, the Parties agree as follows:

1. Definitions

EDI Gateway means CONDUENT EDI Gateway, Inc.

Trading Partner means the party identified as “Trading Partner” on the signature line of this Agreement who is a Health Care Provider or Health Care Clearinghouse as defined in 45 CFR 160.103.

Standard is defined in 45 CFR 160.103.

Transaction and Code Set Regulations means those regulations governing the transmission of certain health claims transactions a s published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Trading Partner

A) The Parties agree, in regard to any electronic Transactions between them:

1) They will exchange data electronically using only those Transaction types as selected by Trading Partner on the CONDUENT EDI Gateway Trading Partner Enrollment Form (TPEF).

2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.

3) They will not change any definition, data condition, or use of a data element or segment in a Standard transaction they exchange electronically.

4) They will not add any data elements or segments to the Maximum Defined Data Set.

5) They will not use any code or data elements that are not in or are marked as “Not Used” in a Standard’s implementation specification.

6) They will not change the meaning or intent of a Standard’s implementation specification.

7) EDI Gateway may reject a Transaction submitted by Trading Partner if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the TPEF. EDI Gateway may refuse to accept any claims from Trading Partner if Trading Partner repeatedly submits Transactions that do not meet the criteria set forth in TPEF or if Trading Partner repeatedly submits inaccurate or incomplete Transactions to EDI Gateway.

B) Trading Partner understands that EDI Gateway or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Trading Partner will participate fully with EDI Gateway in the testing, verification, and implementation of the modification to a Transaction affected by the change.

C) EDI Gateway understands that DHHS may modify the Transaction and Code Set Regulations. EDI Gateway will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Trading Partner and EDI Gateway.

D) Neither Trading Partner nor EDI Gateway accepts responsibility for technical or operational difficulties that arise out of third party service providers’ business obligations and requirements that undermine Transaction exchange between Trading Partner and EDI Gateway.

E) Trading Partner and EDI Gateway will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Trading Partner and EDI Gateway will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

EDI Gateway may publish data clarifications (“Conduent EDI Companion Guides”) to complement each Implementation Guide. Trading Partner should use Conduent EDI Companion Guides in conjunction with the HIPAA Implementation Guides available at http://store.x12.org/store/healthcare-5010- consolidated-guides.

F) Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will properly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received transactions. Each party shall use commercially reasonable efforts to ensure that a Virus is not sent to the other party. Each party agrees that it maintains anti-virus software on its system, which is updated on a regular basis. For the purposes of this Agreement, “Virus” shall mean any "back door", "time bomb", "Trojan horse", "worm", "drop dead device", "virus", "malicious logic", software routines, devices, computer codes, program or hardware components or other undisclosed feature or file which is designed to permit unauthorized access to software, hardware or data, unintentionally or intentionally disrupts, disables, harms, erases, or otherwise impedes the other party's systems, or would disable such software or technology."

G) Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

H) The parties acknowledge that any person, who knowingly and with intent to defraud an insurance company or other person, files a statement of claim containing materially false information or conceals, with intent to mislead, information concerning any fact material to a statement of claim, commits a fraudulent insurance act, which may involve violations of civil and/or criminal law.

3. Miscellaneous

A) This Agreement is effective on the date set forth in Section 3.H, below. This Agreement shall continue until such time as either party elects to give reasonable written notice of termination to the other party or termination of Transaction services provided by EDI Gateway to Trading Partner, whichever is earlier.

B) This Agreement incorporates, by reference, any written agreements between the parties relating to the subject matter hereof.

C) This Agreement shall be interpreted consistently with all applicable federal and state privacy laws. In the event of a conflict between applicable laws, the more stringent law shall be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement shall be governed by and construed in accordance with New York law, exclusive of conflicts of law principles. THE EXCLUSIVE JURISDITION FOR ANY LEGAL PROCEEDING REGARDING THIS AGREEMENT SHALL BE IN THE COURTS OF THE STATE OF New York AND THE PARTIES HEREBY EXPRESSLY SUBMIT TO SUCH JURISDICTION.

D) Unless otherwise prohibited by statute, the parties agree that this Agreement shall not be affected by any state’s enactment or adoption of the Uniform Computer Information Transaction Act, Electronic Signature or any other state or federal law. Each party agrees to comply with all other applicable state and federal laws in carrying out its responsibilities under this Agreement. This Agreement shall not be construed as to impute the application of any law onto a party or require compliance by a party, if such law does not already apply to or require compliance by the party, including but not limited to, the designation of a party as a “covered entity” under HIPAA if such status does not already apply under the law.

E) This Agreement is entered into solely between, and may be enforced only by Trading Partner and EDI Gateway. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of Trading Partner or EDI Gateway to any third party.

F) NO WARRANTIES, EXPRESS OR IMPLIED, ARE PROVIDED BY EDI GATEWAY UNDER THIS AGREEMENT. EDI GATEWAY’S MAXIMUM AGGREGATE LIABILITY FOR

Conduent EDI Gateway, Inc. Provider Agreement

Please return to:

Mississippi Medicaid Program

Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER ARISING OUT OF THIS AGREEMENT, REGARDLESS OF THE MANNER IN WHICH CLAIMED OR THE FORM OF ACTION ALLEGED, IS LIMITED TO THE AMOUNT(S) PAID TO EDI GATEWAY BY TRADING PARTNER UNDER THIS AGREEMENT.

G) EDI Gateway may provide proprietary software to Trading Partner to allow Trading Partner to submit transactions to EDI Gateway. Trading Partner will protect the software as it protects its own confidential information, but in no event shall this protection be less than pursuant to a reasonable standard, and will not directly or indirectly, allow access to or the use of the software or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than Trading Partner. Trading Partner may permit use of the software by contractors or agents of Submitter provided that any such contractor or agents are not competitors of EDI Gateway and further provided that any such persons agree to protect the confidentiality of the software. Trading Partner and its contractors and agents are not permitted to use the software for any purpose other than submitting Transactions solely to EDI Gateway.

H) Trading Partner may elect to execute either a hard copy or an electronic copy of this Agreement. Hard Copy Execution: Trading Partner will sign a hard copy of this Agreement and mail to EDI Gateway at the address indicated below. EDI Gateway will return a copy of the fully executed Agreement to Trading Partner. The effective date of the hard copy Agreement is the date on which the Agreement is signed by EDI Gateway. Electronic Copy Execution: Trading Partner should execute this Agreement by clicking on the "I Agree" button that appears at the bottom of the Agreement. The effective date of the electronic copy agreement is the date EDI Gateway receives the electronic transmission of Trading Partner's Acceptance to the terms of this Agreement.

TRADING PARTNER:

____
Signature

____
Printed Name and Title

____
Date

CONDUENT EDI GATEWAY, INC.
PO Box 23078
Jackson, MS 39225

Fax: 1-888-495-8169

____
Signature

____
Printed Name and Title

____
Date

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Please complete the following Mississippi Medicaid EDI ERA Provider Agreement and Enrollment Form. Please print or type. Complete all areas of the form, unless otherwise indicated. Once the form has been completed and signed, please return it to the address above for processing. You may contact the EDI Support Unit at 1-800-884-3222, Monday-Friday 8AM-5PM CST if you have any questions about the EDI ERA Provider Agreement and Enrollment Form or wish to inquire upon the status of a form that has already been submitted. If you wish to receive dual delivery (paper and electronic) of the Remittance Advices for at least 31 days or 3 payments, whichever is greater; please send a written request to the address above.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*

Trading Partner ID

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email address

Fax Number

Electronic Remittance Advice Information

Account Number Linkage to Provider Identifier*
(**Must Match EFT Preference**)

O Provider Tax Identification Number (EIN/TIN)
O National Provider Identification Number (NPI)

Method of Retrieval*

EDI-ERA Provider Agreement and Enrollment Form

Please return to:
Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Clearinghouse Information

If you have indicated that you plan to use the services of a Billing Agent/Clearinghouse to submit your transactions electronically to Conduent EDI Gateway, please provide the following information regarding the Billing Agent/Clearinghouse. You would need to be able to provide your Billing Agent/Clearinghouse's unique Trading Partner Name and ID. Please contact your Billing Agent/Clearinghouse for this required information. The Trading Partner ID field is located in the Provider Identifiers Information Section of this form.

Clearinghouse Name

Software Vendor Information

If you have indicated that you plan to use the services of a Software Vendor to submit your transactions electronically to Conduent EDI Gateway, please provide the following information regarding your agent. Your Software Vendor is required to enroll and receive their unique Trading Partner ID to test with Conduent EDI Gateway. Please indicate your Software Vendor's Conduent EDI Gateway Trading Partner ID. Please contact your Software Vendor for this required information. The Trading Partner ID field is located in the Provider Identifiers Information Section of this form.

Vendor Name

Submission Information

Reason for Submission*

O New Enrollment
O Change Enrollment
O Cancel Enrollment

EDI-ERA Provider Agreement and Enrollment Form

Please return to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

The following constitutes an Electronic Data Interchange Agreement ("EDI Agreement") between the Health Care Provider and the Mississippi Division of Medicaid ("DOM") or its designated Fiscal Agent. This EDI Agreement defines the requirements for Electronic Data Interchange between the Provider and the DOM or its designated Fiscal Agent. Any references in this EDI Agreement to the submission of electronic transactions, refers to electronically submitted transactions as chosen by the Provider.

Terms of Agreement

The Provider agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the DOM or its designated Fiscal Agent.

The Provider agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Provider agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Provider agrees that if a Billing Agency or Clearinghouse is used for the submission of electronic transactions, the Billing Agency or Clearinghouse identified in Section III must have a Trading Partner Service Agreement on file with the DOM or its designated Fiscal Agent.

If using a Billing Agency or Clearinghouse, the Provider agrees to report information accurately and completely to the Billing Agency or Clearinghouse as required in the Appropriate DOM Electronic Transactions Submission Manual and agrees to be completely responsible for the electronic transactions generated from the information submitted to the DOM or its Fiscal Agent by the Billing Agency or Clearinghouse.

If using a Billing Agency or Clearinghouse, the Provider agrees to not use any Billing Agency or Clearinghouse except the one listed in Section III of this agreement until this EDI Agreement has been terminated in writing to the DOM or its designated Fiscal Agent.

If using an EDI software vendor for submission of electronic transactions, the Provider agrees to insure that all data meets the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

If any information supplied in this EDI Agreement changes at any time during the Provider's enrollment in the Mississippi Medicaid program, the Provider agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this EDI Agreement.

Whenever necessary, this EDI Agreement may be amended by mutual consent of the DOM and the Provider to meet federal or other operational requirements.

The Provider agrees that the EDI Submitter ID is confidential and is not transferable or assignable. This EDI Agreement is not transferable or assignable and may be terminated on thirty (30) days written notice by either party.

This EDI Agreement is automatically terminated in the event the Provider's license is revoked by the Appropriate Board, the Provider is disqualified through a federal administrative action, or as set forth in Miss. Code Ann. Section 43-13-121(l) (1972, as amended).

Authorized Signature

Written Signature of Person Submitting Enrollment*

Printed Name of Person Submitting Enrollment

Submission Date

EDI-ERA Provider Agreement and Enrollment Form

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number.

Trading Partner ID – Enter the trading partner ID of the billing agent, clearinghouse, or vendor that will be receiving the 835 on behalf of the provider.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title – Enter the title of the Provider Contact person.

Telephone Number – Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension – Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address – Enter the email address of the Provider Contact Person.

Fax Number – Enter the fax number of the Provider Contact Person.

Electronic Remittance Advice Information

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is an atypical provider, otherwise check the National Provider Identification Number (NPI) radio button.

Method of Retrieval* - Enter one of the following methods for retrieving the electronic remittances advices: EDI Online, MS Envision Web Portal, Hyper Terminal, or Bulletin Board System.

EDI-ERA Provider Agreement and Enrollment Form

INSTRUCTIONS
Required fields are denoted with an asterisk (*).

Clearinghouse Information

Clearinghouse Name – Enter the name of the clearinghouse designated to process 835s on behalf of the provider.

Software Vendor Information

Vendor Name - Enter the name of the vendor designated to process 835s on behalf of the provider.

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for ERA. Check the Change Enrollment radio button if this application is to make a change to an existing provider's ERA information. Check the Cancel Enrollment radio button if this application is to cancel an existing provider's ERA and change to the paper RA instead.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

Missing ERA Procedures

- The provider will contact the Conduent EDI Support Unit (1-800-884-3222, option 2 then 4) to submit a research request.
- If possible, the electronic remittance advice will be reposted within 3 to 5 business days.

Late ERA Procedures

- The provider will contact the Conduent EDI Support Unit (1-800-884-3222, option 2 then 4) to submit a research request.
- If it was found that the files are late posting, then the files will be made available within 24 to 48 hours.