Division of Medical Services
Medical Assistance Program

PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement, all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew, or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit on the portal OR complete this *electronic form, print, and mail to:

Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105

*To access the digital signature field, the form must be opened using the Acrobat Reader desktop application. Forms viewed with Acrobat Reader within an internet browser window may not show the digital signature field. Download the form to your computer, open with Acrobat Reader, enter required information, and save the file before uploading to the portal.

All dates, except where otherwise specified, should be written in the month/day/year (MM/DD/YYYY) format. Please print all information legibly to avoid delays with your application.

This information is divided into sections. The following describes which sections are to be completed by the applicant:

- Section I ..... All Providers
- Section II ..... Facilities Only
- Section III ..... Pharmacists/Registered Respiratory Therapist Only
- Section IV ..... Provider Group Affiliations
- Electronic Fund Transfer ..... All Providers (EFT is required for facilities, but is optional for most individuals)
- Managed Care Agreement ..... Primary Care Physician
- W-9 Tax Form ..... All Providers
- Contract ..... All Providers
- Ownership and Conviction Disclosure ..... All Providers
- Disclosure of Significant Business Transactions ..... All Providers

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

_____
MM / DD / YYYY

Item (2) or (3) must be completed, but NOT both.

(2) **Last Name, First Name, Middle Initial, and Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

_____ _____ _____ _____
Last Name First Name M.I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity. If entering any other name such as an organization, corporation, or facility, enter the full name of the entity in item 3.

Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name (Doing Business As)

Must submit documentation that the above fictitious name is registered with the appropriate board within your state (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Select one of the following codes which coincide with fields 2 or 3. Each application type listed below will be required to complete *Disclosure Forms (**DMS-675** – Ownership and Conviction Disclosure and **DMS-689** – Disclosure of Significant Business Transactions.)

***NOTE: If these forms are not completed and attached, the application will be denied.**

- ☐ 0 = Individual Practitioner (i.e., physician; dentist; a licensed, registered or certified practitioner)
- ☐ 1 = Sole Proprietorship (This includes individually owned businesses)
- ☐ 2 = Government Owned
- ☐ 3 = Business Corporation, for profit
- ☐ 4 = Business Corporation, non-profit ****copy of Tax Form 501 (c) (3) must accompany this application**
- ☐ 5 = Private, for profit
- ☐ 6 = Private, non-profit ****copy of Tax Form 501 (c) (3) must accompany this application**
- ☐ 7 = Partnership
- ☐ 8 = Trust
- ☐ 9 = Chain

**** NOTE: if the tax form is not attached, the application will be denied.**

(5) **SSN/FEIN Number:** Enter the Social Security Number of the applicant OR the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

___ ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Social Security Number Date of Birth

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

___ _____ - _____ _____ _____ _____ _____ _____ _____
Federal Employee Identification Number

(6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

National Provider Identification Number

Taxonomy Code

(7) **Service Location**

(A) Enter the applicant's service location address (Line 1), include suite number if applicable. THIS FIELD IS MANDATORY (Must be a physical location).

Address Line 1

(B) Enter any additional street address (Line 2).

Address Line 2

(C) City, State, Zip+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine-digit zip code.

City | AR | State | Zip Code+4

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

Area Code | Telephone Number

(E) Fax Number – enter the area code and fax number of the location in which the services are provided.

Area Code | Fax Number

(8) **Billing Street Address**

(A) This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address; P.O. Box may be entered in billing address.

City | AR | State | Zip Code+4

Area Code | Telephone Number

Area Code | Fax Number

(B) **Provider Manuals and Updates**

Please review Section I sub-section 101.000; 101.200; and 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Providers will receive emails notifying them of applicable manual updates, official notices, notices of rule making and provider memos that are available on the Division of Medical Services website. The website is updated as needed.

Email address

When providing your email address, please do the following:

- Please ensure your email address is legible.
- Use a generic email address that more than one person can access (e.g., xyzclinic@yahoo.com instead of janedoe@yahoo.com). Email addresses often become outdated when an individual leaves a practice or clinic.
- Make sure the email address will accept email from 'gainwelltechnologies.com'. You may have to instruct your network administrator or email provider to accept emails from 'gainwelltechnologies.com'. *Arkansas Medicaid* sends email in bulk and some email services block bulk email unless instructed otherwise.

(9) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

01 Arkansas

(10) **Provider Category (A-C)**
Select from the following drop down lists the services the applicant will be providing.

(A) 01 Physician, MD (Solo Practitioner) 01 General Practice

(B) _____

(C) _____

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in fields 12 and 13 unless the entry is a 5.

Please check the appropriate code.

- ☐ 0 = Mental Health
- ☐ 1 = Home Health
- ☐ 2 = CRNA
- ☐ 3 = Nursing Home
- ☐ 4 = Other
- ☐ 5 = Non-applicable

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.
A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

_____
MM / DD / YYYY

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

_____
MM / DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies and Dental Surgeons
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

_____
MM / DD / YYYY

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license, enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

_____
MM / DD / YYYY

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required to have your laboratory test paid**.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

SECTION II: FACILITIES ONLY

(20) **Special Facility Program:** Check the appropriate value to depict if the applicant's facility is indigent care, teaching facility/university or UR plan. Special facility program values include:

- ☐ *A = Indigent care only
- ☐ **B = Teaching facility/university only
- ☐ ***C = UR plan only
- ☐ D = A/B
- ☐ E = A/C
- ☐ F = B/C
- ☐ G = A/B/C
- ☐ N = No special program

* Indigent Care - Indicate whether the facility is qualified for the indigent care allowance.

NOTE: Facilities which serve a disproportionate number of indigent patients (defined as exceeding 20% Medicaid days as compared to a total patient day) may qualify for an indigent care allowance. If the facility meets the above criteria, please send the appropriate excerpt from the most current cost report that reflects total Medicaid days and total patient days.

** Teaching/University Facility - Indicate whether the facility is designated as a teaching/university affiliated institution and participates in three or more residency training programs.

*** Utilization Review Plan - Does the facility have a Utilization Review Plan applicable to all Medicaid patients?

(21) **Total Beds:** Enter the total number of beds in the facility.

_____
# of Beds

SECTION III: PHARMACIST/REGISTERED RESPIRATORY THERAPIST ONLY

PHARMACIES - PLEASE INDICATE IF THIS APPLICANT IS A CHAIN-OWNED PHARMACY with 11 or more retail pharmacies nationally. (Franchises that are individually owned are not chain-owned unless one individual or corporation owns 11 or more retail stores.)

☐ **YES** ☐ **NO**

(22) Please list each pharmacist/registered respiratory therapist name, Social Security Number, license number and effective date of employment.

Please indicate by the pharmacist's name whether that pharmacist is certified to administer Vaccines. If you are providing Vaccines, the pharmacy will need to be enrolled in the Medicare program. Please include the pharmacy Medicare Billing Provider ID Number on the Medicare Verification Form and attach proof of Medicare enrollment to the application. Please refer to the Medicare Verification Form for proof of Medicare requirements.

A copy of current registered respiratory therapist is required. Subsequent renewal must be provided when issued.

NOTE: Registered Respiratory Therapists must enter registration number in license number field.

Administering Vaccines? (see above)

_____ _____ ☐ yes ☐ no
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number

_____ _____
License/Registration Number — Effective Date of Employment

_____ _____ ☐ yes ☐ no
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number

_____ _____
License/Registration Number — Effective Date of Employment

_____ _____ ☐ yes ☐ no
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number

_____ _____
License/Registration Number — Effective Date of Employment

_____ _____ ☐ yes ☐ no
Name of Pharmacist/ Registered Respiratory Therapist — Social Security Number

_____ _____
License/Registration Number — Effective Date of Employment

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

Last Name _____ First Name _____ M.I. _____ Title _____

Group Organization Name _____

Group Medicaid ID _____

Effective Date (Date Provider Joined Group) _____ Expiration Date (Date Provider Left Group) _____

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; Arkansas Medicaid will accept electronic signatures, in compliance with Arkansas Code § 25-31-103, et seq.

Provider Signature _____ Title _____ Date _____

Typed or Printed Name _____ Provider Medicaid ID _____

Primary Care Physicians must complete the Primary Care Physician Agreement to have their managed care fees paid to a new group Provider Medicaid ID Number.

Division of Medical Services
Gainwell Technologies Provider Enrollment Unit
P.O. Box 8105, Little Rock, AR 72203-8105
P: (501) 376-2211 WATS: (800) 457-4454 F: (501) 374-0746

Authorization for Electronic Funds Transfer (Automatic Deposit)

Dear Provider:

Provider Enrollment will no longer accept provider enrollment applications without a completed authorization for **Electronic Funds Transfer (EFT**) form for all enrolling facilities and individual providers not eligible for section IV group linkage. Providers must utilize EFT, which allows your Medicaid payments to be directly deposited into your bank account. In addition to providing more secure payment and decreased administrative costs, you will notice a difference in your cash flow with EFT because it makes your money available sooner than the actual clearance date of paper checks. Arkansas Medicaid appreciates your cooperation in allowing us to be more efficient and environmentally friendly.

When enrolling as a Medicaid provider, you **must** complete the Authorization for Electronic Funds Transfer form AND attach a voided check or a letter from the bank that includes

- Account holder's name
- Bank account number (ABA)
- Routing number

Payments will be made to the provider Medicaid ID listed as the "billing provider" on a claim. If billing under a group billing Medicaid ID as a "rendering provider;" claim payments will always be paid to the biller's Medicaid ID and the bank account registered to the group's Medicaid enrollment.

Managed Care Payments: PCCM payments are paid to the Medicaid ID listed on their PCP agreement.

Voided Check Requirements: If submitting a voided check, the name printed on the check must match the enrolling provider's name submitted on their application. We recommend:

- Individual providers: submit EFT information that will direct payment to the provider's personal checking account matching their enrolling name.
- Providers linked to a group: submit EFT information with their group's banking information registered in the business/facilities name and a bank letter.

Bank Letter Requirements: If a bank letter is required, it must include

- Account holder's name
  The account holder's name must match the provider's name **or** indicate the provider has depositing rights into the account.
- Bank account number (ABA)
- Routing number
- Authorized bank employee's signature

Provider Enrollment will no longer accept faxed copies of this form or attachments. EFT changes and attachments can be submitted through provider portal (preferred) or mailed to the address at the bottom of the EFT form.

Requests to update EFT information will be verified by a provider enrollment analyst. Before processing any EFT changes (except new enrollments), the provider will be called at the phone number on file for their Medicaid ID only. The Enrollment Analyst will ask to confirm the change was requested.

If you have any further questions concerning this letter, please contact the Provider Assistance Center locally at (501) 376-2211 or (800) 457-4454 toll free.

Sincerely,
Arkansas Department of Human Services

Authorization for Electronic Funds Transfer
(Automatic Deposit)

Name of Medicaid Provider _____

Provider Medicaid ID # _____ (Enter "pending" for new enrollment)

Type of Authorization ☐ New ☐ Change ☐ Cancel

A copy of a **voided check** or a **letter from the bank** is required to verify these numbers. The name on the voided check or letter from bank **must match the name of the Medicaid provider stated above.** Temporary checks are **not** accepted.

☐ Checking ☐ Savings (if not indicated, this will **automatically be entered as "checking."**)

_____ _____
ABA Transit Number Bank Account Number

_____
Name of Bank

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

_____ _____
Printed name Job title

_____
Provider's Original Signature (required)

Submit EFT changes through the portal or mail this form and attachments to:

Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN (PCP) MANAGED CARE PROGRAM

PCP PARTICIPATION AGREEMENT

• General Practitioner (including osteopath)
• Internal Medicine • Family Practitioner • Pediatrician
• Obstetrician • Gynecologist • Certified Nurse-Midwife

If your specialty of practice is listed above, you **MUST** complete the Primary Care Physician Participation Agreement and the EPSDT Agreement to participate in the Arkansas Medicaid Program. Please refer to Section I of your Arkansas Medicaid Provider manual for information concerning the Primary Care Physician Program.

*** NOTE *** Providers whose specialty is either Internal Medicine or Obstetrician/Gynecology have the option of enrolling in the Child Health Services (EPSDT) program, please review the Primary Care Physicians policy in Section I of your Arkansas Medicaid Provider manual.

This agreement is made and entered into between _____
(Please print or type provider's name)

hereafter called provider, and the Arkansas Division of Medical Services, hereafter called Medicaid.

The provider in consideration of the material benefits to be derived, and the rules and regulations of the Medicaid Program agrees as follows:

A. To be a Medicaid enrolled Physician provider and comply with all pertinent Medicaid policies, regulations, and State Plan standards.

B. To be a Medicaid enrolled Early Periodic Screening Diagnosis and Treatment (EPSDT) provider and to comply with all pertinent Medicaid policies, regulations, and State Plan standards. (Internists, Obstetricians/Gynecologists are exempt from this requirement.)

C. To perform various services as a primary care physician under the guidelines of the Primary Care Physician Managed Care Program and to comply with all pertinent Medicaid policies, regulations, and State Plan standards.

D. To authorize their name be listed as a primary care physician and consent to release their name to interested parties.

Managed Care 24-hour number:_____

Requested Effective Date:_____ (Currently enrolled providers only)

Please indicate the maximum number of Medicaid beneficiaries you are willing to accept for primary care services.

(a maximum of **2500**): _____

Please indicate the **Provider Medicaid ID Number** (individual or group) for your management care fee payment designation and

inclusion on a Federal 1099 Tax Form: _____
Provider Medicaid ID Number

Physicians without hospital admitting privileges, please list the name of the enrolled PCP with admitting privileges who has agreed to be responsible for your beneficiary inpatient admissions:

_____ **An agreement signed by the PCP and the Admitting physician is required.**

County Codes

****Please** indicate all the counties in Arkansas in which you will provide primary care physician services by checking the county codes designated below. You can select a maximum of 20 counties. If more than 20 counties are selected, you must include a statement letter explaining the need for more than 20 counties. DHS will review and approve/deny requests for more than 20 counties.

Add +	Remove -	County Code/Name		Add +	Remove -	County Code/Name		Add +	Remove -	County Code/Name	
☐	☐	01	Arkansas	☐	☐	26	Garland	☐	☐	51	Newton
☐	☐	02	Ashley	☐	☐	27	Grant	☐	☐	52	Ouachita
☐	☐	03	Baxter	☐	☐	28	Greene	☐	☐	53	Perry
☐	☐	04	Benton	☐	☐	29	Hempstead	☐	☐	54	Phillips
☐	☐	05	Boone	☐	☐	30	Hot Spring	☐	☐	55	Pike
☐	☐	06	Bradley	☐	☐	31	Howard	☐	☐	56	Poinsett
☐	☐	07	Calhoun	☐	☐	32	Independence	☐	☐	57	Polk
☐	☐	08	Carroll	☐	☐	33	Izard	☐	☐	58	Pope
☐	☐	09	Chicot	☐	☐	34	Jackson	☐	☐	59	Prairie
☐	☐	10	Clark	☐	☐	35	Jefferson	☐	☐	60	Pulaski
☐	☐	11	Clay	☐	☐	36	Johnson	☐	☐	61	Randolph
☐	☐	12	Cleburne	☐	☐	37	Lafayette	☐	☐	62	Saline
☐	☐	13	Cleveland	☐	☐	38	Lawrence	☐	☐	63	Scott
☐	☐	14	Columbia	☐	☐	39	Lee	☐	☐	64	Searcy
☐	☐	15	Conway	☐	☐	40	Lincoln	☐	☐	65	Sebastian
☐	☐	16	Craighead	☐	☐	41	Little River	☐	☐	66	Sevier
☐	☐	17	Crawford	☐	☐	42	Logan	☐	☐	67	Sharp
☐	☐	18	Crittenden	☐	☐	43	Lonoke	☐	☐	68	St. Francis
☐	☐	19	Cross	☐	☐	44	Madison	☐	☐	69	Stone
☐	☐	20	Dallas	☐	☐	45	Marion	☐	☐	70	Union
☐	☐	21	Desha	☐	☐	46	Miller	☐	☐	71	Van Buren
☐	☐	22	Drew	☐	☐	47	Mississippi	☐	☐	72	Washington
☐	☐	23	Faulkner	☐	☐	48	Monroe	☐	☐	73	White
☐	☐	24	Franklin	☐	☐	49	Montgomery	☐	☐	74	Woodruff
☐	☐	25	Fulton	☐	☐	50	Nevada	☐	☐	75	Yell
								☐	☐	76	Pulaski North
☐	☐	91	Louisiana	☐	☐	94	Oklahoma	☐	☐	96	Texas
☐	☐	92	Missouri	☐	☐	95	Tennessee	☐	☐	97	Other States
☐	☐	93	Mississippi								

Please note: Per Section I, subsection 171.160, item A of the Arkansas Medicaid provider manuals, a PCP must be physically located in the State of Arkansas or in a bordering state trade-area city. The trade-area cities are:

- **Monroe** and **Shreveport**, Louisiana
- **Clarksdale** and **Greenville**, Mississippi
- **Poplar Bluff**, Missouri
- **Poteau** and **Sallisaw**, Oklahoma
- **Memphis**, Tennessee
- **Texarkana**, Texas

PCP Provider Medicaid ID Number _____ Primary Care Physician Signature _____ Date _____

AGREEMENT TO PARTICIPATE

as a Screening Provider in the Arkansas Child Health Services Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

This agreement made and entered into this ____ day of _____, 20___ and between

_____ , hereinafter called Provider, and Arkansas Division of Medical Services.

The provider, in consideration of the material benefits to be derived, and the covenants and undertakings of Arkansas Division of Medical Services agree as follows:

A. To perform various components of the screening examination in accordance with exemplary age-specified Child Health Services (EPSDT) screening procedures:

B. To bill for screening services only after services have been provided in accordance with the current Arkansas Child Health Services (EPSDT) medical periodicity schedule:

C. To permit provider's name to be listed as a full screening provider with the Child Health Services (EPSDT) program and consent to inclusion on Child Health Services (EPSDT) provider list made available to county Human Services staff for selection by eligible beneficiaries. School Based Child Health providers are excluded from this requirement as they provide services only to those beneficiaries enrolled in their individual school.

In witness whereof the Parties hereto have set their hands in duplicate the day and date first written above.

_____
Provider Original Signature

_____ _____
Provider Identification Number Taxonomy Code

_____
Effective Date of Change

FORM W-9
Request for Taxpayer
Identification Number and Certification

The Department of Finance and Administration and the Department of Human Services have mandated that an IRS form W-9 be completed by all vendors doing business with the Department of Human Services.

NOTE:

To ensure correct processing of the 1099, please review the following:

- When billing for services under a clinic name and IRS number, the **clinic** and **each individual Medicaid provider** (i.e., physician, therapist, dentist, etc.) **MUST enroll** by completing a **separate** application and contract.

- The clinic provider Medicaid ID number must be placed in the **PAY TO** field and the individual provider Medicaid ID number must be placed in the **PERFORMING** field. This will ensure that the 1099 reflects the correct tax number.

- Please refer to your provider manual for claims processing instructions.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

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 of the person whose name is entered on line 1. 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: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its 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.) See instructions.

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

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, *later.*

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,* later, 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 Pub. 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 24% 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 instructions for Part II 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,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

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,* later, 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 (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a 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 on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on 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. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

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.

If you are a single-member LLC that is disregarded as an entity separate from its owner, 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 *What Name and Number To Give the Requester,* later, 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. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

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 item 1, 4, or 5 below indicates 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), ABLE accounts (under section 529A), 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) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. 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]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. 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:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. 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
15. 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,* earlier.

***Note:** The 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 Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic 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 report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* 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.

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the 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. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

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

Wholly owned supplier: 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.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, physical address and PO Box address and each location, complete Social Security Number and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals

For each individual listed, provide date of birth and COMPLETE Social Security Number

Full Name	Date of Birth	Complete Primary Address and PO Box Address	% of Interest	Complete Social Security Number
			0%	
			0%	
			0%	

Corporations/Limited Liability Companies/Partnerships/Other Legal Entities or Organizations

For each legal entity or organization listed, provide the Tax ID Number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application. Companies must include each business address location with complete addresses.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number
		0%	
		0%	
		0%	
		0%	
		0%	

Are any of the above-mentioned persons related to each other as a spouse, parent, child, or sibling?

☐ Yes ☐ No If yes, print name and provide relationship.

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program?

☐ Yes ☐ No If yes, print name, address and Tax ID Number and amount of % of interest they own.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number
		0%	
		0%	
		0%	
		0%	
		0%	

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

List the name, address, date of birth, and complete Social Security Number for any person who is a managing employee of the named entity. For larger corporations having more than 3 managing employees or board members, please use next page (4)*.

Name	Address	Date of Birth	Complete Social Security Number

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XIX programs in any state:

Name	Offense

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

***Use this sheet for multiple business managers/owners or board members.**

Name	Address	Date of Birth	Complete Social Security Number

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. Additionally, by completing and signing this form, I give consent for the Arkansas Department of Human Services to request, copy, access, and use State and Federal criminal records and other information about the Owner(s) and Managing Employee(s) in order for the Department to determine the status with the Arkansas Medicaid program. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name _____ Title _____

Signature _____ Date _____

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and business transaction information is required. Upon request, the provider must furnish all records described in the provider contract within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, full and complete information about:

1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2) Any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Full, complete, and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attach to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

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

Wholly owned supplier: 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.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

Submit full, accurate and complete disclosure concerning the following information:

1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12-month period ending as of the date on this application).

_____

_____

_____

2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5-year period ending as of the date of this application).

_____

_____

_____

3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5-year period ending as of the date of this application).

_____

_____

_____

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

_____ _____
Name Title

_____ _____
Signature Date

CONTRACT

to Participate in the Arkansas Medical Assistance Program Administered by the Division of Medical Services Under Title XIX (Medicaid)

Instructions

Please ensure the provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

CONTRACT
to Participate in the Arkansas Medical Assistance Program
Administered by the Division of Medical Services Title XIX (Medicaid)

The following agreement is entered into between _____, hereinafter called Provider, and the Arkansas Department of Human Services, hereafter called Department:

I. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries, these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.

1. In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as “Confidential Information."

2. The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations.“

C. To make available and, upon request, furnish all records described above within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, full and complete information about:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2. Any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

D. To accept assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid).

E. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message.

F. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the beneficiary or accept any additional payment from the beneficiary except cost share (co-pay or deductible amounts) established by the Medicaid Program.

G. To take assignment and file claims with third party sources (medical or liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for

the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party source discovered after submission of a claim or claims to Medicaid.

H. To make no charge to a beneficiary for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of a peer reviewer; except that such charge may be made to the beneficiary when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined "not medically necessary."

I. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

J. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

K. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

L. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

M. To certify by <u>original</u> signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this certification as a matter of record for all claims submitted electronically, by any media.

N. To notify the Department before any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered before the change in ownership or operating status.

O. FOR HOSPITALS ONLY

To understand that the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospitals, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

P. To authorize for the Arkansas Department of Human Services to request, copy, access, and use the Provider’s State and Federal criminal records and other information for the Department to determine the Provider’s status with the Arkansas Medicaid program.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above-named Provider for the appropriate Medicaid covered services provided to eligible Medicaid beneficiaries in accordance with the applicable Medicaid reimbursement schedule in effect for the dates of service, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above-named Provider of applicable changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any medical records received by the Department or its fiscal intermediary, as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:

1. Returned mail

2. Death of provider

3. Change of ownership

4. Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

Provider Name: _____
(As inscribed on previous page of contract)

By: _____
(Signature Required)

Name: _____
(Typed or Printed Name Required)

Title: _____
(Required)

Date: _____
(Required)

DATA SHARING AGREEMENT

between

the Division of Medical Services
Arkansas Medicaid

and

_____

Insurance or Managed Care Plan Providing Medicare Part C
("Medicare Advantage") and/or Part D Services

WITNESSETH:

Based upon the following recitals, the Division of Medical Services and

_____ (hereinafter referred to as

"Medicare Plan"), FEI # _____, enter into this data sharing agreement.

ARTICLE I. PURPOSE

The Centers for Medicare and Medicaid Services (CMS) has issued correspondence to Medicare Plans on the policies and procedures for initiating corrections to CMS' low-income subsidy data for plan enrollees for whom the plan has documentation about their Arkansas Medicaid eligibility or residence in an institution under a Medicaid-covered stay. CMS further has provided guidance for Medicare Advantage Special Needs Plans that cover individuals eligible for both Medicare and Medicaid, requiring such plans to verify eligibility through, among other means, a systems query to a State Medicaid eligibility data system. The purpose of this data sharing agreement is to provide the "best available evidence" (BAE) of Medicaid eligibility to the Medicare Plans through access to the Arkansas Medicaid Management Information System (MMIS), while protecting the confidentiality of the data which is transferred.

ARTICLE II. THE PARTIES

2.0 **Division of Medical Services**

a.) Division of Medical Services (DMS) states that it is the single state agency that administers the Arkansas Medicaid Program.

b.) Division of Medical Services has authority to enter into this Agreement.

c.) Division of Medical Services states that its mailing address for purposes of this Agreement is as follows:

Provider Enrollment
Gainwell Technologies
P. O. Box 8105
Little Rock, AR 72203-8105

2.1 **Medicare Plan**

a.) The Medicare Plan provider states that it has authority to enter into this Agreement pursuant to its contractual arrangement with the CMS for the purpose of

determining dual eligibility of persons qualifying for the Medicare Advantage and/or Medicare Part D prescription drug program.

b.) The Medicare Plan provider states that its mailing address for purposes of this Agreement is as follows:

Company Name:_____

Attention:_____

Address: _____

City:_____

State: AR _____ Zip: _____

ARTICLE III. TERMS

3.0 **Modifications**

This Agreement contains all the agreements of the parties and no oral representation by either party is binding. Any modifications to this Agreement must be in writing and signed by both parties prior to the effective date of the modification.

3.1 **Assignment**

Neither party shall assign or transfer any rights or obligations under this Agreement without the prior written consent of the other party.

ARTICLE IV. SCOPE OF WORK – DATA SHARING

4.0 The Division of Medical Services shall allow the Medicare Plan to enroll in the Arkansas Medicaid Program by completing a Provider Enrollment application. This application can be accessed online or by contacting the Provider Enrollment Unit.

4.1 The Medicare Plan will receive a welcome letter containing a provider number, and an effective date which will allow the Medicare Plan access to verify client eligibility. The Medicare Plan will not submit claims for processing.

4.2 The Medicare Plan will receive a Remittance Advice weekly of the number of eligibility verifications conducted.

ARTICLE V. CONFIDENTIALITY, PRIVACY and SECURITY

5.0 The Medicare Plan agrees that Arkansas Medicaid recipient information is confidential and is not to be released to the general public.

5.1 The Medicare Plan agrees not to release the information governed by these Arkansas Medicaid recipient requirements to any other state agency or public citizen without the approval of the Division of Medical Services.

5.2 The use or disclosure of information concerning recipients shall be limited to purposes directly connected with the administration of the state's Arkansas Medicaid program and eligibility verification relating to Medicare Advantage and/or Medicare Part D plans.

5.3 This restriction shall also apply to the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

5.4 Medicare Plan agrees that Arkansas Medicaid recipient and provider information cannot be re-marketed, summarized, distributed, or sold to any other organization without the express written approval of the Division of Medical Services.

5.5 Medicare Plan agrees to comply with the Federal Privacy Regulations and the Federal Security Regulations as contained in 45 C.F.R. Parts 160 through 164 that are applicable to such party as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 U.S.C. §§ 1320d -1320d-8.

5.6 Medicare Plan must report any known breach of confidentiality, privacy, or security, as defined under HIPAA, to the Division of Medical Services Privacy and Confidentiality Officer within 48 hours of knowledge of an unauthorized act. Failure to perform may constitute immediate termination of contract.

ARTICLE VI. LAWS APPLICABLE

6.0 The parties agree to abide by all federal and state statutes applicable to this Agreement.

6.1 The explicit inclusion of some statutory and regulatory duties in this Agreement shall not exclude other statutory or regulatory duties.

6.2 All questions pertaining to validity, interpretation and administration of this Agreement shall be determined in accordance with the laws of the State of Arkansas, regardless of where any service is performed.

6.3 If any portion of this Agreement is found to be in violation of federal or state statutes, that portion shall be stricken from this Agreement and the remainder of the Agreement shall remain in full force and effect.

ARTICLE VII. TERMINATION

7.0 This Agreement may be terminated by either party for cause with a thirty (30) day written notice to the other party. Either party may terminate without cause with a sixty (60) day written notice to the other party. All notices of termination must be in writing.

7.1 In the event funding of the Arkansas Medicaid program from the state, federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Agreement and prior to the anticipated Agreement expiration date, this Agreement may be terminated immediately by the Division of Medical Services.

7.2 Violation of the confidentiality provisions of this Agreement, as outlined in Article V, shall be grounds for immediate termination.

EXECUTED BY:

_____

Name and Title (printed) of Medicare Plan Authorized Designee

_____ _____

Signature Date