Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

QMB

Below is a checklist for your convenience to ensure all required forms are completed in their entirety. ***If any of the following items are not complete, do not have original signatures, are not dated, or if the items specified on the Type & Specialty page are not included, your entire application will be returned.***

Sign the application in BLUE ink. This helps minimize any confusion regarding original signatures. Copies of signed forms and/or stamped signatures are not acceptable.

Unless otherwise noted, all requirements apply to individual applicants as well as group applicants.

- ☐ **Application Information**

- ☐ **Kansas Medical Assistance Program (KMAP) Provider Application**
  Original signature and date are required.
  If a question is not applicable, mark N/A in the corresponding field.

- ☐ **Billing Agent and Clearinghouse**

- ☐ **Disclosure of Ownership and Control Interest Statement**
  Name, phone number, and address must be filled in.
  All questions or boxes must be completed or checked.
  An original signature and date are required on Page 8 of 8.

- ☐ **KMAP Provider Agreement**
  All four boxes on the first page must be completed.
  An original signature and date must be on Page 6 of 6.
  Note: If the effective date requested is prior to the signature date of the provider agreement, see Page 6 of 6. You must include a claim for the requested effective date.

- ☐ **Current license**
  An expired license will not be accepted.
  The license must be from the state in which the provider will be practicing and must be valid for the requested effective date.

- ☐ **Copy of Medicare acceptance letter or Medicare explanation of medical benefits (EOMB) covering requested effective date**

- ☐ **W-9**
  A copy of the W-9 is required with a signature. The date on the document must be within 12 months of the date it is received by KMAP.

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WELCOME TO KMAP

Thank you for your interest in the Kansas Medical Assistance Program (KMAP). All of the application materials within this document must be completed and returned to the fiscal agent for your enrollment to be processed. A checklist of required documentation has been provided for your convenience. Submission of incomplete application materials will delay your enrollment. In order to facilitate the assignment of a provider number, complete and submit the application materials with ORIGINAL SIGNATURES. Please retain copies of your application materials for your records. You will receive written notification upon approval or denial of your enrollment.

All claims must be received by the current fiscal agent within one year from the date of service. Claims not received in a timely manner (within one year from the date of service) will not be considered for reimbursement except for claims submitted to Medicare, claims determined to be payable by reason of appeal or court decision, or as a result of agency error.

Regulations regarding payment of services to out-of-state providers (more than 50 miles from the Kansas border) allow payment consideration for out-of-state services provided to KMAP beneficiaries if one of the following situations exists:

- An out-of-state provider may be reimbursed for covered services required on an emergency basis.
    - An emergency is defined as those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
    - In these situations, contact the KMAP Prior Authorization department to receive authorization prior to services being rendered. Failure to contact the Prior Authorization department may result in denial of your claim.
- An out-of-state provider may be reimbursed for nonemergency services if the Prior Authorization department, on behalf of the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), determines that the services are medically necessary.

Note: Failure to meet either of the above situations may result in denial of your claim.

If either situation presently exists or may exist, then complete the enclosed application forms and provide all of the requested information.

If you have questions concerning enrollment, contact Provider Enrollment.

- PO Box 3571, Topeka, Kansas 66601
- 1-800-933-6593, option 3 (between 8:00 a.m. and 5:00 p.m., Monday through Friday)

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APPLICATION INFORMATION

Name _____ Title _____

Tax ID # _____ Social Security # _____

Date of birth _____ State _____

County _____ Group # _____

NPI # _____ CLIA # _____

Medicare # _____ Insurance _____
(Need effective and end date for standardized application)

Admit privileges_____
(For MDs & DOs, need effective date)

License information for practice/service address:

State _____ License #_____ Effective date _____ Expiration date_____

TYPE OF PRACTICE (check only one):

Corporation ☐ Government ☐ Hospital Physician ☐ Partnership☐ Not for Profit☐
Privately Owned ☐ Sole Proprietor ☐ Individual Practice☐

==========

For HP use only. Do not use.

CTMS _____ RECD DATE _____ PROVIDER # _____

New ☐ Duplicate ☐ Reactivation ☐ 18-month reactivation ☐ Revalidation ☐ App Fee ☐

Group Members _____

Sanction Information:

SAM (OIG)	☐
LEIE (OIG)	☐
SSDMF	☐
NEW WAVE	☐
NPPES	☐
License	☐

EFFECTIVE DATE_____

Provider request ☐ _____ Agreement date ☐ _____
DOS of claim ☐ _____ Admit date ☐ _____
License date ☐ _____ Medicare ☐ _____
CDDO date ☐ _____ Policy ☐ _____
State request ☐ _____ Insurance date ☐ _____
Other ☐ _____

HP Notes

_____ Request date _____

_____ Reason _____

_____ State response _____

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KMAP PROVIDER APPLICATION

Choose one: ☐ **New Enrollment** ☐ **Revalidation**

This application must be completed in its entirety. Do not leave any questions blank.
If a question is not applicable, indicate so with an N/A in the appropriate field.
Incomplete applications will result in a delay in processing.

SECTION A

BUSINESS NAME OR PROVIDER NAME

OR PROVIDER
First Middle Last

PROVIDER'S SOCIAL SECURITY NUMBER

PROVIDER'S TAX IDENTIFICATION NUMBER

PROVIDER'S LICENSE/CERTIFICATION NUMBER

LICENSE/CERTIFICATION EFFECTIVE AND EXPIRATION DATES
From To

PROVIDER'S NPI **TAXONOMY CODE**
A copy of the letter or email received from NPPES assigning the NPI is required.

DEA NUMBER

GROUP NUMBER
If a group number is not indicated, the provider will not be listed as a member of the group.

GROUP NPI **GROUP TAXONOMY CODE**

WAS THE PREVIOUS PROVIDER ENROLLED IN THE KANSAS MEDICAL ASSISTANCE PROGRAM?

YES ☐ NO ☐

PREVIOUS KMAP PROVIDER NAME AND NUMBER

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES

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TYPE OF PRACTICE ORGANIZATION

☐ INDIVIDUAL PRACTICE	☐ PARTNERSHIP	☐ CORPORATION
☐ MUNICIPAL OR STATE-OWNED	☐ PRIVATELY OWNED	☐ LLC
☐ HOSPITAL-BASED PHYSICIAN	☐ CHARITABLE	☐ OTHER

PROVIDER'S PHYSICAL LOCATION (This is the practice or physical site location.)

ADDRESS

CITY STATE COUNTY ZIP CODE *(nine digits)*

PHONE NUMBER EXT FAX NUMBER

EMAIL ADDRESS

PROVIDER'S MAIL TO ADDRESS (This is the address to which correspondence will be mailed.)

ADDRESS

CITY STATE ZIP CODE *(nine digits)*

PHONE NUMBER EXT UMBER

EMAIL ADDRESS

PROVIDER'S PAY TO ADDRESS (This is the address to which payments will be mailed.)

PAYEE NAME

ADDRESS

CITY STATE ZIP CODE *(nine digits)*

PHONE NUMBER EXT FAX NUMBER

EMAIL ADDRESS

PROVIDER'S HOME OFFICE ADDRESS (This is the address of business home office.)

ADDRESS

CITY STATE ZIP CODE *(nine digits)*

PHONE NUMBER EXT FAX NUMBER

EMAIL ADDRESS

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SECTION B

For groups or professional associations only.

NAME OF GROUP

EXISTING GROUP? YES ☐ NO ☐

EXISTING GROUP KMAP PROVIDER NUMBER NPI

A copy of the letter or email received from NPPES assigning the NPI is required.

GROUP SPECIALTY TAXONOMY CODE

GROUP'S TAX IDENTIFICATION NUMBER

If new group, effective date KMAP beneficiaries will be seen

If a group, please list all members in the group.

NAME	CREDENTIALS	KMAP PROVIDER ID

If additional space is needed, attach a separate sheet.

SECTION C

PROVIDER SPECIALTY/PRACTICE DATA

USING THE TYPE & SPECIALTY PAGE ATTACHED, INDICATE THE KMAP SPECIALTY REQUESTED.

PRIMARY

SECONDARY

KANSAS SCHOOL DISTRICT (for physical location)

Kansas Medical Assistance Program
P O Box 3571
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SECTION D

Are you a proprietor, investor, partner, superintendent, executive officer, business member, or consultant of any clinical lab, diagnostic or testing center, hospital, surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies?

YES ☐ NO ☐

If yes, please provide the following information:

NAME OF ORGANIZATION

TAX IDENTIFICATION NUMBER **TELEPHONE NUMBER**

STREET ADDRESS **CITY**

STATE **ZIP CODE**
(nine digits)

TYPE OF ORGANIZATION **SIZE OF ORGANIZATION**

PERCENT OF BUSINESS OWNED/INVESTED BY PRACTITIONERS OR HOSPITALS

PERCENT OF BUSINESS OWNED/INVESTED BY APPLICANT

NATURE OF BUSINESS INTEREST
(for example owner, partner, investor)

IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.

SECTION E

LABORATORY INFORMATION

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires all providers at all locations performing laboratory testing, including in-office laboratories, to be registered with the CLIA program.

CLIA NUMBER

EFFECTIVE DATE

CANCELLATION DATE

Kansas Medical Assistance Program
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SECTION F

Kansas Medical Assistance Program Provider Binder

I certify, under penalty of perjury, that the information and statements on this application and on any accompanying documents are accurate and true. I understand that the filing of materially incomplete or false information with this enrollment request is sufficient cause for denial of enrollment or termination from the Kansas Medical Assistance Program.

I understand that should I be enrolled as a provider of services under the Kansas Medical Assistance Program, that it is my responsibility to notify the Kansas Medical Assistance Program fiscal agent of any change to the information on this application including but not limited to address, group affiliation, change of ownership, or tax identification number.

PROVIDER SIGNATURE

Authorized signature

By

Title

Date

Contact person for questions pertaining to this application.

Name

Phone number

Please mail completed application to:

Provider Enrollment Department
P.O. Box 3571
Topeka, KS 66601-3571

Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

BILLING AGENT AND CLEARINGHOUSE

Do you use a billing agent and/or clearinghouse for any Kansas Medicaid function? ☐ Yes ☐ No

If yes, provide the following information:

Billing agent (if applicable)

Entity name:	
Entity address:	
Direct contact name:	
Direct contact number:	
Direct contact email address:	

Clearinghouse (if applicable)

Entity name:	
Entity address	
Direct contact name:	
Direct contact number:	
Direct contact email address:	

STATE OF KANSAS
Disclosure of Ownership and Control Interest Statement

The Kansas Medical Assistance Program (KMAP) is required to collect disclosure of ownership, control interest and management information from providers who participate in Medicaid or the Children's Health Insurance Program (CHIP) and the federal regulations set forth in 42 CFR Part § 455. Required information includes:

1) The identity of all owners and others with a control interest of 5% or greater as described in 42 CFR § 455.104;
2) The identity of managing employees, agents and others in a position of influence or authority as described in 42 CFR § 455.104
3) Certain business transactions as described in 42 CFR § 455.105; and
4) Criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN) as described in 42 CFR § 455.106.

Completion and submission of this Disclosure of Ownership and Control Interest Statement is a condition of participation in KMAP. The Disclosure of Ownership and Control Interest Statement must be submitted upon enrollment; upon executing a provider agreement/contract; upon request of the Medicaid agency during revalidation; and within 35 days after any change in ownership of the disclosing provider entity.

Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement/contract, or termination of existing provider agreement/contract.

Fill in each section. Every field must be complete. If fields are blank or the form is unreadable (e.g. due to illegible handwriting), the form will be returned for corrections/completeness and not processed.

Instructions for Disclosure of Ownership and Control Interest Statement

If additional space is needed, please note on the form the answer is being continued, and attach a sheet referencing the question number being continued. (For example: Question 1 Ownership Information, continued). Please see Glossary for definitions of bolded terms.

Providing the SSN and TIN (as applicable) is required under 42 CFR § 455.104; Any Statement without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Question 1 - 2 Ownership Information:
List the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Control Interest. If the Owner is a corporation, the primary business address must be listed and every business location and P.O. Box address.

Question 3 Ownership in Other Providers & Entities:
Please identify all other providers or entities owned or controlled by the individual(s) or organization(s) identified in question 1. This information is to identify shared and interconnected ownership and control interests.

Question 4 Familial Relationships of All Owners:
Only group providers answer this question. Report whether any of the persons listed in Questions 1, 2, 5, and 6 are related to each other and identify the parties and their relationship.

Question 5 Business Transactions with any Subcontractor:
Identify all subcontractors the provider entity had business transactions with totaling more than $25,000 during the preceding 12-month period.

Question 5a Subcontractor Ownership:
List the Ownership of all Subcontractors the provider entity had business transactions totaling more than $25,000 within the last twelve (12) month period.

Question 6 Significant Business Transactions with any Wholly Owned Supplier or Subcontractor Information:
List any ***Significant Business Transactions*** between provider entity and any Wholly Owned Supplier or Subcontractor during the past 5 years.

Question 7 Managing Employees
List information for all managing employees such as general manager, business manager, president, vice-president, CEO, CFO, administrator, director, board of directors, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Question 8 Outstanding Debt
Provide information on family or household members of individuals listed in questions 1-7 who have outstanding debt with any state Medicaid program or any other Federal agency or program.

Questions 9-11 and 12a Criminal Convictions, Adverse Legal Actions, Sanctions, Exclusions, Debarment, and Terminations:
List your own criminal convictions, adverse legal actions, exclusions, sanctions, debarments, and terminations, ***and*** for any person who has an ownership or control interest, or is an agent or managing employee of the provider entity. List all offenses related to each person's or provider entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs.

Question 12 Participation in Medicaid or Medicare
List the provider entities or individuals who have participated, previously or currently, in KMAP, any other state's Medicaid program, or Medicare regardless of the timeframe.

Question 13 Provider Entity subject to Section 6032 of the Deficit Reduction Act
Provider entities receiving payments in any federal fiscal year (October 1 to September 30) of at least $5 million from the KMAP and KanCare managed care organizations (MCOs) are subject to the provisions contained within Section 6032 of the Deficit Reduction Act of 2005 (Pub. L.109-171).

Question 14 Contact Person
This question is self-explanatory.

Question 15 Address for Location of Records
This question is self-explanatory.

STATE OF KANSAS
Disclosure of Ownership and Control Interest Statement

Name of Provider Entity/Individual		EIN/SSN	
Date of Birth (for individual)	NPI	Taxonomy	
Physical Address	City/State	Zip Code	

Fiscal agents and all providers must answer each question except where noted. If more space is needed, provide the information on a separate piece of paper and attach to this document.

1. Do you have an ***ownership or control interest*** in the provider/fiscal agent/managed care entity or in any ***subcontractor*** in which the provider/fiscal agent has ***direct or indirect ownership*** of five percent or more? If Yes, give their information below.
42 CFR 455.104(b)(1)(i); 42 CFR 455.104(b)(1)(ii); 42 CFR 455.104(b)(1)(iii)

Yes ☐
No ☐

#	Name (individual or corporation)	Primary Address	Email Address	Date of Birth (for individual)	Social Security Number (for individual) or Tax Identification Number (for corporation)	% of ownership
1A.						
1B.						
1C.						
1D.						
1E.						

2. Are any persons named in question #1 related to each other? If yes, give the name(s) of person(s) and relationship(s) such as spouse, parent, child, or sibling.
NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.
42 CFR 455.104(b)(2)

Yes ☐
No ☐

#	Name	Relationship

3. Does any person (individual or corporation) named in question #1 have an ***ownership or control interest*** in any other Medicaid provider or in any provider entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or provider entity. *NOTE: Designate association to each person listed in question #1 by using 1A, 1B, 1C, etc.* *42 CFR 455.104(b)(3)*	Yes ☐ No ☐

#	Name	Address	Tax Identification Number

Question 4 answered by group providers only.

4. Are any provider members of the group related to the listed owners or those with an ***ownership or control interest*** listed in question #1? *NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.*	Yes ☐ No ☐

#	Name	Relationship	Date of Birth	Social Security Number

5. Has the provider entity had business transactions with any ***subcontractor*** totaling more than $25,000 during the preceding 12-month period? If yes, give the information below for each ***subcontractor***. *42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)*	Yes ☐ No ☐

#	Name	Address	Date of Birth (if individual)	Social Security Number (if individual) or Tax Identification Number
5A.				
5B.				
5C.				
5D.				
5E.				

5a. Provide the following for all provider entities or persons with an ***ownership or control interest*** in each ***subcontractor*** named in question #5.

*Note: Designate association to **subcontractor** listed above by using 5A, 5B, 5C, etc.*

42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)

#	Name	Address	Date of Birth	Social Security Number or Tax Identification Number

6. Has the provider entity had any ***significant business transactions*** with any ***wholly owned supplier*** or with any ***subcontractor*** during the preceding five year period? If yes, give the information below for each ***wholly owned supplier*** or ***subcontractor***.

42 CFR 455.105(b)(2)

Yes ☐
No ☐

Name	Address	Description of Business Transaction

7. Provide the following information on all ***managing employees*** of the provider entity.

NOTE: This question cannot be blank.

42 CFR 455.104(b)(4)

Name	Address	Date of Birth	Social Security Number
A.			
B.			
C.			
D.			
E.			

8. Does any family or household members of <u>any</u> of the provider entities or individuals listed under any question in this Statement have any outstanding debt with any state Medicaid program or any other Federal agency or program? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt. *NOTE: Designate association to each person listed in this question by using 1A, 1B, 5A, 5B, etc.*					Yes ☐ No ☐	
#	Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt

9. Has the provider entity, or any person who has ***ownership or control interest*** in the provider, or any person who is an ***agent*** or ***managing employee*** of the provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, provide the following information below. *42 CFR 455.106(a)(2)*		Yes ☐ No ☐
Name	Description	Date

10. Have <u>any</u> of the provider entities or individuals listed under any question in this Statement had any of the following healthcare related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program: • Criminal Conviction • Administrative Sanction • Program Exclusion • Suspension of Payment • Civil Monetary Penalty • Assessment • Program Debarment • Criminal Fine • Restitution Order • Pending Civil Judgment • Pending Criminal Judgment • Judgment Pending Under False Claims Act If yes, provide the following information below and attach copy of the adverse legal action notification(s).	Yes ☐ No ☐

Name	Program	State	Action	Date

11. Have <u>any</u> of the provider entities or individuals listed under any question in this Statement had any of the following non- healthcare related adverse legal actions: • Criminal Conviction • Administrative Sanction • Program Exclusion • Suspension of payment • Civil Monetary Penalty • Assessment • Program Debarment If yes, provide the following information below and attach copy of the adverse legal action notification(s).	Yes ☐ No ☐

Name	Program	State	Action	Date

12. Have <u>any</u> of the provider entities or individuals listed under any question in this Statement ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, provide the following information below.	Yes ☐ No ☐

Name	Program	State

12a. Have any of the provider entities or individuals in question #12 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, provide the following information below.			Yes ☐ No ☐
Name	Program	State	Date

12b. Do any of the provider entities or individuals listed in question #12 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes ☐ No ☐
Name	Program	State	Amount of Debt	Date

13. Is the provider entity part of a provider entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, provide the following below.		Yes ☐ No ☐
Name of Provider or Provider Entity	Address of Provider or Provider Entity	Tax Identification Number of Provider or Provider Entity

14. Provide the following information for the contact person for audit purposes.	
Name	Title
Phone Number	Email Address

15. Provide the address for the physical location of the records required under K.A.R. 30-5-59. *NOTE: P.O. Boxes and drop boxes are not acceptable.*		
Address	City/State	Zip Code

ANY DOCUMENTATION OR ANSWERS PROVIDED ON THIS APPLICATION, INCLUDING THE LACK OF DOCUMENTATION OR ANSWERS, MAY BE USED IN THE CONSIDERATION OF THIS APPLICATION FOR APPROVAL. THE STATE WILL ONLY CONSIDER APPROVAL OF APPLICANTS THAT IT DETERMINES TO HAVE MET THE FEDERAL, STATE AND AGENCY GUIDELINES FOR PROGRAM INTEGRITY AND PROVIDER ENROLLMENT.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE PROVIDER ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY OF HEALTH AND HUMAN SERVICES AS APPROPRIATE.

Name of Application Preparer (Typed or Printed) _____

Name of Authorized Agent (Typed or Printed) _____

Signature of Authorized Agent _____

Title of Authorized Agent _____

Date _____

GLOSSARY

***Agent*:** any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing provider entity.

Determination of ownership or control percentages: (a) indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each provider entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing provider entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing provider entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing provider entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing provider entity and need not be reported. (b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing provider entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

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

Group Providers: a provider who has members affiliated to them.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Indirect Ownership Interest: an ownership interest in a provider entity that has an ownership interest in the disclosing provider entity. This term includes an ownership interest in any provider entity that has an indirect ownership interest in the disclosing provider entity.

Individual Provider: a healthcare practitioner who is solely practicing or is a member of a group or facility and who is licensed or certified by the state in which he/she delivers services and is credentialed and/or enrolled as a Medicaid participating provider.

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation such as president, vice-president, CEO, CFO and board of directors.

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

Ownership or Control Interest: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing provider entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing provider entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing provider entity;
(d) 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 provider entity;
(e) Is an officer or director of a disclosing provider entity that is organized as a corporation; or
(f) Is a partner in a disclosing provider entity that is organized as a partnership.

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing provider entity.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other provider entity with an ownership or control interest in the Provider Entity.

K A N S A S

Kansas Medical Assistance Program

Provider Agreement

1. Provider's Name	2. Physical Address (street, city, state & zip)
3. Pay-to Name (if different than information given in No. 1)	4. Pay-to Address (street, city, state & zip)

Terms and Requirements

1. Rules, Regulations, Policies

The provider agrees to participate in the Kansas Medical Assistance Program (KMAP) and to comply with all applicable requirements for participation as set forth in federal and state statutes and regulations, and Program policies, within the authorities of such statutes and regulations, of the Kansas State Medicaid Agency (SMA) as published in the KMAP Provider Manuals and Bulletins. The provider also agrees to comply with all state and federal laws and regulations applicable to services delivered and professional activities.

The provider agrees that the KMAP General Provider Manuals and the Provider Manuals specific to the program and services, Provider Manual revisions and Provider Bulletins are a part of this agreement and are wholly incorporated by reference. The provider agrees to read them promptly. The Manuals represent Medicaid program limitations and requirements that providers must follow to receive payment and to continue participation in the Medicaid program under K.A.R. 30-5-59(c)(1). The Manuals are in addition to the requirements of the Medicaid Provider Agreement and any other contracts such as managed care contracts and contracts with other insurance carriers. The fiscal agent for the KMAP has prepared the Manuals for the SMA, but the requirements and limitations in the Manuals are the official requirements and limitations of the relationship between providers and the SMA. Please use the Manuals whenever billing or communicating with the KMAP.

The Manuals make available to Medicaid providers informational and procedural material needed for the prompt and accurate filing of claims for services rendered to KMAP consumers. The Manuals are not a complete description of all aspects of KMAP. Should a conflict occur between Manual material and laws and regulations regarding the KMAP, the latter takes precedence.

From time to time, program policies will change. The SMA will notify the provider in the form of bulletins and revised Manual pages published on the KMAP Website, and upon publication of those revised Manual pages, the contract between providers and the SMA is amended. It is important that all revisions be placed in the appropriate section of the Manual and obsolete pages removed when applicable. You may wish to keep obsolete Manual pages to resolve coverage questions for previous time periods.

The Manuals represent the official policy and interpretations of regulations of the SMA in the administration of the KMAP. No provider may claim, in any judicial or administrative proceeding or hearing, that the SMA modified or interpreted the Manuals based simply on an oral conversation unless such interpretation or modification was reduced to writing and signed by the Secretary of the SMA. The fiscal agent for the KMAP has no authority to modify or interpret the Manuals.

*(**Note:** The provider must read the General Provider Manuals and all other applicable Provider Manuals before providing services to beneficiaries. Providers must follow documentation standards contained in the manuals beginning on the first date of service.)*

2. Ownership Disclosure

The provider agrees that all required ownership and operating information is fully and truthfully disclosed on the Disclosure of Ownership and Control Interest Statement which is included as part of the Provider Application.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or the U.S. Department of Health and Human Services (HHS) full and complete information about 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.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS full and complete information about any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS a full and complete updated Disclosure of Ownership and Control Interest Statement.

3. Change of Ownership

The provider agrees to report and disclose all required changes in ownership and operating information and that any reported or unreported changes may affect the status of this provider agreement. The provider agrees to report such change of ownership to the fiscal agent for the KMAP within thirty-five (35) days. Changes of ownership or tax identification number terminate this agreement and the new owner or provider must reapply and submit an updated Disclosure of Ownership and Control Interest Statement.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

4. Enrollment

An individually enrolled provider agrees that each provider performing services (except those services performed under the personal direction of an enrolled provider) must be individually enrolled in the KMAP and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to Kansas Medical Assistance consumers by the non-enrolled provider will be denied or, if paid in error, recouped by KMAP.

5. Internal Revenue Service (IRS) Reporting

The provider agrees that the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS and that as a member of a group practice an individual provider, billing as an individual rather than as a member of a group, cannot use the FEIN of the group practice. The provider acknowledges that the KMAP will report income to the IRS using only the SSN or FEIN of the billing provider or payee and that no income will be reported using the SSN or FEIN of the performing provider.

6. License, Certification, Registration

The provider agrees to maintain required licensed, certified or registered status for all categories for which participation is sought.

7. Record Keeping and Retention

The provider agrees that standardized definitions, accounting, statistics and reporting practices which are widely accepted in the provider field shall be followed and that all records necessary to disclose fully the payments claimed and services rendered shall be accurately maintained in a manner which is retrievable for a period of five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. The provider agrees that this record keeping requirement is not a limit on the ability of the SMA to recoup overpayments; overpayments can be recouped beyond the five year limit.

8. Access to Records, Confidentiality and Routine Review

The provider agrees that routine reviews may be conducted by the Department of Health and Human Services, the SMA, or its designee of services rendered and payments claimed for KMAP consumers and that during such reviews the provider is required to furnish to the reviewers records and original radiographs and other diagnostic images which may be requested. If the required records are retained on machine readable media, a hard copy of the records must be made available when requested. The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. Providers shall follow all applicable state and federal laws and regulations related to confidentiality.

9. Claims for Services Rendered

The provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to KMAP for payment. The provider agrees that the services listed on all claims are medically necessary for the health of the patient and are personally furnished by the provider or by the provider's employee under the provider's personal direction, the charges for such services are just, unpaid, and actually due according to federal and state statutes and regulations and Program policy, as announced in KMAP Provider Manuals and Bulletins and are not in excess of regular fees; the information provided on the claim is true, accurate and complete; and the words "on file" or "signature on file" when placed on the KMAP claim refers to the provider's signature on this document.

10. Timely Filing of Claims

The provider agrees that all claims must be received by the KMAP fiscal agent within twelve (12) months from the date the service was provided and that claims which are originally received within twelve (12) months from the date of service but are not resolved before the twelve (12) month limitation expires, may be corrected and resubmitted up to twenty-four (24) months from the date of service.

11. Payment

The provider agrees to accept as payment in full, subject to audit, the amount paid by the KMAP, with the exception of authorized co-payment and spenddown. The provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Program costs, payments may be pended or reduced and a payment plan as determined by the Secretary of the SMA will be developed within federal and state guidelines.

12. Billing the Consumer

The provider agrees that claims for covered services not submitted within twelve (12) months of the date of service, when the provider has knowledge of KMAP coverage, cannot be billed to the consumer and that claims which are timely filed and subsequently denied because of provider errors cannot be billed to the consumer if the provider fails to correct the errors and resubmit the claim. A provider may bill consumers for services not covered by KMAP if the provider notified the consumer of the non-coverage prior to the provision of services. The consumer must acknowledge the notification in writing.

13. Overpayment

The provider agrees that if it received payment for services or goods in an amount in excess of payment permitted by the KMAP that such overpayments may be deducted from future payments otherwise payable to the provider or the provider associated with the provider's tax identification number or service location. The provider acknowledges that such remedy is not the only or exclusive remedy available to the SMA and that collection of the overpayment begins after its right to Administrative Review has been exhausted.

If funds have been overpaid or disallowed, the provider shall, within thirty (30) days of discovery by the provider or notification by the SMA or its agent, repay or make arrangements to repay on other terms approved by the SMA to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a provider of medical services and legal action by the SMA to recover such funds, including the legal rate of interest.

14. Fraud

The provider agrees that payment of claims is from federal or state funds, or both, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable federal or state laws. The provider acknowledges that he/she is accountable for claim information submitted personally by them or by their authorized employee regardless of the media by which the provider submits claims. The provider acknowledges that the submission of a false claim, cost report, document or other false information, charging the recipient for covered services except for authorized spenddown and co-payment, and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable federal and state laws. Among such applicable laws is K.S.A. 21-3844 et.seq. and amendments thereto (the Kansas Medicaid Fraud Control Act).

15. Termination

The provider agrees that the SMA may terminate a provider's participation in the Kansas Medical Assistance Program for noncompliance with one or more terms of this provider agreement or applicable state and federal laws and regulations. Among such applicable regulations are K.A.R. 30-5-60 and 42 CFR § 455 et. seq.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

16. Civil Rights and 504 Compliance Assurances

The provider understands that the SMA policy is to comply with the applicable nondiscrimination, equal opportunity and affirmative action provisions of various federal and state laws, regulations and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. The provider understands that this compliance policy covers employment policies, practices, services, benefit programs and activities. The provider understands that the SMA will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the basis of race, color, national origin, ancestry, religion, age, sex, disability or political affiliation.

The provider shall agree: (a) to observe the provisions of the Kansas Act Against Discrimination and to not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, disability unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisements for employees, to include the phrase, "equal opportunity employer/service provider," or a similar phrase to be approved by the Kansas Human Rights Commission; (c) if the provider fails to comply with the manner in which the provider reports to the commission in accordance with the provisions of K.S.A. 44-1031, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; (d) if the provider is found to have committed a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Human Rights Commission that has become final, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; and (e) the provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor.

The provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin. The provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations are at 45 Code of Federal Regulations, Part 80.)

The provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of disability. (Specific regulations found at 45 Code of Federal Regulations, Part 84.) The provider assures that all services will be provided in compliance with the provisions of the Americans With Disabilities Act of 1990, which prohibits discrimination on the basis of disability. (Specific regulations are at 29 Code of Federal Regulations, Part 1630.)

The provider assures that all services will be provided in compliance with the provisions of the Age Discrimination in Employment Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations are at 45 Code of Federal Regulations, Part 90.)

17. Professional Standards

The provider agrees to comply with all state and federal laws, regulations, and professional standards applicable to services and professional activities provided to KMAP consumers

18. Provider Agreement Term and Effective Date

This Provider Agreement shall be continuous and ongoing as long as the provider meets the requirements for participation in the KMAP including periodic reenrollment as required by the SMA. The provider agrees that this Provider Agreement is effective if all requirements for enrollment are met on the date of signing by the provider, or may be effective no more than twelve (12) months prior to the signing if a claim for covered services has been received by the KMAP fiscal agent. If all requirements are not met, the date on which such requirements are met shall be the effective date of this Provider Agreement.

19. Signature of Provider:

I certify by my signature, under penalty of perjury, that I am the individual named in Box 1, page 1, or I am duly authorized by the person listed in Box 1, page 1, to bind such person to the terms of this Provider Agreement and that I have read and understand the Provider Agreement and all applicable Provider Manuals and Bulletins.

Provider signature:

By: _____

Printed Name: _____

Title: _____

Date: _____

Acceptance by the Secretary of the State Medicaid Agency

By _____ Date _____
Manager, Kansas Medical Assistance Program Provider Enrollment

Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

ELECTRONIC SUBMISSION

Submit Kansas Medical Assistance Program claims electronically.

Benefits to submitting claims electronically include:

- Claims adjudicate within minutes
- Cost savings in postage, paper, and ink
- Reduced time in claim preparation

Benefits to submitting electronic claims directly to the fiscal agent include:

- Submitters only need to contact **the fiscal agent** for submission problems; there are no intermediaries.
- Claim adjudication occurs within minutes when submitting fee-for-service (FFS) claims directly to **the fiscal agent;** intermediaries often transmit claims the next day.
- No fees are associated with submissions to **the fiscal agent**.

The fiscal agent offers two free solutions for electronic claims.

- **KMAP secure website –** Claims can be filed online using the secure website. Claim adjudication occurs within seconds and allows any mistakes on a claim to be corrected and resubmitted. Beneficiary eligibility, claim status, prior authorization, pricing, and pharmacy NCPDP services are also available. Use of the KMAP secure website does not require an EDI application or an authorization test.

- **Provider Electronic Solutions –** This batch billing software allows a batch of institutional or professional claims to be uploaded to the KMAP secure website. Claim adjudication occurs within hours. Beneficiary eligibility, claim status, prior authorization, and pharmacy NCPDP transactions can also be created. Use of batch billing software requires an EDI application and an authorization test.

Another electronic claims solution:
Third-party software – A provider can select a software that meets his or her needs. An EDI application and an authorization test are required before submitting claims for payment. The electronic claims clearinghouse (intermediary) must be authorized with the fiscal agent.

For any questions regarding electronic claims or authorization testing, contact the EDI Help Desk:

- **1-800-933-6593**
- LOC-KSXIX-EDIKMAP@groups.ext.hpe.com

Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

ELECTRONIC FUNDS TRANSFER (EFT)

The State of Kansas offers electronic deposit to providers who request this service. Electronic deposit provides the highest degree of certainty that payments will be delivered securely, without the delays that can occur with paper warrants.

To sign up for electronic deposit, an Authorization for Electronic Deposit of Vendor Payment form must be completed and returned to the Kansas Department of Health and Environment, Division of Health Care Finance.

To request a form be mailed or faxed, please call:
Customer Service
1-800-933-6593

If you have questions completing the form, please call:
Kansas Department of Health and Environment, Division of Health Care Finance
785-296-3981 (Ask for the Finance department.)