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

# STANDARD

Below is a checklist for your convenience to ensure all forms are completed in their entirety.
***If any of the following items are not complete, do not contain original signatures, or are not dated, or if required items 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**

☐ **Standardized Credentialing Application**
Page 5, Section 4: Doctors must have staff membership before they will be allowed to enroll.
Page 8, Section 8: Insurance information must cover requested effective date.
Page 9, Section 9: Malpractice information must be completed and signed if marked yes.
Page 10, Section 10: All 15 questions must be answered; any yes answers must be explained.
If a group number is not indicated, the provider will not be listed as a member of a group.
**Group application**: Disregard Pages 3-11; Page 1 must have group name; Page 2, questions 1-13 must be completed.

☐ **Type & Specialty page**: A specialty must be marked.

☐ **Provider Binder**: Original signature and date are required.

☐ **Provider Attestation**

☐ **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.
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.
**Group application**: Include license copies for at least two group members enrolled with KMAP. A list of KMAP identification (ID) numbers may be attached for additional group members.

☐ **W-9:** A copy of the W-9 is required.

☐ **Application fee, if applicable**
Refer to General Bulletin 17298 attached to this application.

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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______________________________ Provider type ______________________________
(For MDs & DOs, need effective date) (Put appropriate number from Type & Specialty page)

Provider specialty(s) ______________________________ ______________________________
(Put appropriate number from Type & Specialty page)

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 ______________________________



*Created 02.2013*

**Choose One:** ☐ **New Enrollment** ☐ **Revalidation**

# STANDARDIZED CREDENTIALING APPLICATION

*To be used by health care organizations licensed in the State of Kansas*

COMPLETE EACH SECTION AS THOROUGHLY AS POSSIBLE. PLEASE TYPE OR PRINT.

## I. GENERAL INFORMATION

1. ________________________________________
Name (Last, First, MI, Degree/Prof. Designation-M.D./D.O./Ph.D./M.S.W./D.C./D.P.M./ D.M.D./A.P.N./P.A./Other)

2. ________________________________________
Home address/Street

3. ____________________
City/County/State/ZIP

4. ____________________
Email address

5. ____________________
Other names you may have used (i.e. maiden, etc.)

6. ____________________
Date of birth (month/day/year)

7. ____________________
Place of birth

8. ____________________
Social Security number

9. Are you a U.S. citizen? Yes ____ No ____

10. Sex: Male ______ Female ______

If not a citizen of the U.S., indicate the current status of your VISA:

________________________________________

________________________________________

# II. OFFICE/PRACTICE INFORMATION

If more than two offices, check here ______ and attach a copy of Page 3, completing questions 22-40 for each office.

1. Participation status for which you are applying: (Indicate specialty)
   Primary Care: __________ Specialty: __________ Subspecialty: __________ Both: ________ Patient Ages: ________
2. ____________________
   PRIMARY OFFICE Address/Street/Building/Suite
3. ____________________
   City/County/State/ZIP Should this practice be listed in provider directory? Yes ________ No _______
4. ____________________
   Tax ID # owner/Corporate name as appears on SS4 or W-9 form (or full legal name)
5. ____________________
   Business name or name by which the provider group is generally known
6. ____________________
   Office phone number
7. ____________________
   After hours/Emergency number or procedure
8. ____________________
   Office fax number
9. ____________________
   Office email address
10. ____________________
    Office manager
11. ____________________
    Federal tax ID#
12. ____________________
    Billing address/Street (if different from above)
13. ____________________
    Billing city/State/ZIP
14. List routine office hours:

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | | | | |

15. Evening hours: Yes ________ No _______ If yes, list hours after 5:00 P.M.

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | | | | |

16. Weekend hours: Yes ________ No _______

| Saturday | Sunday |
|---|---|
| | |

17.(a) Lab service in your office?
Yes ________ No ________

17.(b) ____________________
If yes, specify Waived, Physician Performed Microscopy, Moderately Complex, or Highly Complex.

18. Please check all of the following list that you perform IN THIS OFFICE:- **N/A**

EKG _____ Office gynecology (Routine pelvic/PAP) _____ Drawing blood _____ Age-appropriate immunizations ______
X-rays ______ Minor surgery _____ Tympanometry/audiometry screening _____ Flexible sigmoidoscopy _____
Laceration repair _____ Pulmonary function studies _____ Asthma treatment ______ Allergy skin testing ______
Osteopathic manipulation ____ IV hydration/treatment _____ Other (please specify) ____________________

19. (a) Languages spoken (other than English): ____________________
    (Health Care Provider)
    (b) Are interpreters available? Yes _____ No _____
    ____________________
    (Staff)
20. Does your office: (CIRCLE ONE)
    (a) Have 24-hr. phone coverage service? Y N
    (b) Qualify as a minority business enterprise? Y N
    (c) Have capability for electronic billing? Y N
    (d) Provide child care services for patients? Y N
    (e) Meet ADA accessibility standards? Y N
    (f) Have public transportation accessibility? Y N
    (g) Collaborate with an Advanced Nurse Practitioner or Physician Assistant (P.A)? Y N
    If yes, provide a copy of appropriate collaborative practice or P.A. agreement(s) & the name(s) of the individual(s).
    (h) Type of practice: Solo Single Specialty Group Multispecialty Group Other
    If group practice, attach a list of other members of your practice, their specialties, and coverage arrangements.
21. Do you currently: (CIRCLE ONE)
    (a) Accept new patients into practice? Y N
    (b) Accept new patients by physician referral only? Y N
    (c) Have Medicare certification? Y N
    (d) Accept Medicare assignment? Y N
    (e) Provide inpatient care? Y N
    (f) Accept Medicaid assignment? Y N

## II. OFFICE/PRACTICE INFORMATION (continued)

Attach additional copies as necessary.

22. ______________________________
**SECONDARY OFFICE** Address/Street/Building/Suite

23. ______________________________
City/County/State/ZIP Should this practice be listed in provider directory? Yes ________ No ________

24. ______________________________
Tax ID# owner/Corporate name as appears on SS4 or W-9 form (or full legal name)

25. ______________________________
Business name or name by which the provider group is generally known

26. ______________________________ 27. ______________________________
Office phone number | After hours/Emergency number or procedure

28. ______________________________ 29. ______________________________
Office fax number | Office email address

30. ______________________________ 31. ______________________________
Office manager | Federal tax ID#

32. ______________________________
BILLING ADDRESS/STREET (if different from above)

33. ______________________________
Billing city/State/ZIP

34. List routine office hours:

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | | | | |

35. Evening hours: Yes ________ No ________ If yes, list hours After 5:00 p.m.

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| | | | | |

36. Weekend hours: Yes ________ No ________

| Saturday | Sunday |
|---|---|
| | |

37.(a) Lab service in your office:
Yes ________ No ________

37.(b) ______________________________
If yes, specify Waived, Physician Performed Microscopy, Moderately Complex, or Highly Complex.

38. Please check all of the following list that you perform IN THIS OFFICE:

| | | | |
|---|---|---|---|
| EKG ______ | Office gynecology (Routine pelvic/PAP) ______ | Drawing blood ☐ | Age-appropriate immunizations ______ |
| X-rays ______ | Minor surgery ______ | Tympanometry/audiometry screening ______ | Flexible sigmoidoscopy ______ |
| Laceration repair ______ | Pulmonary function studies ______ | Asthma treatment ______ | Allergy skin testing ______ |
| Osteopathic manipulation ______ | IV hydration/treatment ______ | Other (please specify) ______________ | |

39. (a) Languages spoken (other than English): (b) Are interpreters available? Yes ______ No ______

______________________________ ______________________________
(Health Care Provider) (Staff)

40. Does your office: (CIRCLE ONE)

(a) Have 24-hr. phone coverage service? Y N
(b) Qualify as a minority business enterprise? Y N
(c) Have capability for electronic billing? Y N
(d) Provide child care services? Y N
(e) Meet ADA accessibility standards? Y N
(f) Have public transportation accessibility? Y N
(g) Collaborate with an Advanced Nurse Practitioner or Physician Assistant (P.A)? Y N
If yes, provide a copy of appropriate collaborative practice or P.A. agreement(s) & the name(s) of the individual(s).
(h) Type of practice: Solo Single Specialty Group Multispecialty Group Other
If group practice, attach a list of other members of your practice, their specialties, and coverage arrangements.

## III (A). PROFESSIONAL EDUCATION

List all medical schools/institutions attended.
Please explain any 30-day or greater gap in your training. Attach additional sheets if necessary.

1. ______________________________
Medical/Professional school name

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip/Country

4. From: __________ To: __________ 5. ______________________________
Dates attended (month/year) Degree(s) awarded

6. If you are a graduate of a foreign medical school, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)?
If yes, please enclose a copy of your certificate with this application.
Yes __________ No __________

## III (B). POSTGRADUATE TRAINING: INTERNSHIP

1. ______________________________
Institution name

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip

4. From: __________ To: __________ 5. ______________________________
Dates attended (month/year) Department chair/Program director

6. ______________________________
Type of internship (rotating/straight) - If straight, please list specialty.

## III (C). POSTGRADUATE TRAINING: FIRST RESIDENCY

1. ______________________________
Institution name

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip

4. From: __________ To: __________ 5. ______________________________
Dates attended (month/year) Department chair/Program director

6. ______________________________
Type of residency

## III (D). POSTGRADUATE TRAINING: SECOND RESIDENCY OR FELLOWSHIP

1. ______________________________
Institution name

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip

4. From: __________ To: __________ 5. ______________________________
Dates attended (month/year) Department chair/Program director

6. ______________________________
Type of residency/fellowship

# III E. POSTGRADUATE TRAINING: FELLOWSHIP/OTHER

1. ______________________________
Institution name

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip

4. From: ____________ To: ____________ 5. ______________________________
Dates attended (month/year) Department chair/Program director

6. ______________________________
Type of fellowship/Other explanation

# IV A. HOSPITAL AFFILIATIONS: PRIMARY

1. ______________________________
CURRENT PRIMARY HOSPITAL NAME

2. ______________________________
Address/Street

3. ______________________________
City/State/Zip

Status of Privileges Key

| | | | | |
|---|---|---|---|---|
| 1 Active | 4 Associate | 7 Courtesy | 10 Senior Staff | 13 Consulting |
| 2 Courtesy Provisional Staff | 5 Visiting | 8 Admitting | 11 Provisional | 14 Pending |
| 3 Active Provisional Staff | 6 Temporary | 9 CO-Admitting | 12 Suspended | 15 Other: ________ |

4. ______________________________ 5. From: ____________ To: ____________
Status of privileges *(INDICATE BY USING KEY)* Dates attended (month/year)
*If CO-Admitting status, list other admitting physician(s).* ______________________________

6. Any past or present restriction of privileges? Yes ______ No ______ *(IF YES, EXPLAIN)*

______________________________

# IV B. HOSPITAL AFFILIATIONS: OTHER

**List all other hospitals at which you have or have had privileges.** Attach additional pages if necessary.

1a. ______________________________
HOSPITAL NAME

2a. ______________________________
Address/Street

3a. ______________________________
City/State/Zip

4a. ______________________________ 5a. From: ____________ To: ____________
Status of privileges *(INDICATE BY USING KEY)* Dates attended (month/year)
*If CO-Admitting status, list other admitting physician(s).* ______________________________

6a. Any past or present restriction of privileges? Yes ______ No ______ *(IF YES, EXPLAIN)*

______________________________

1b. ______________________________
HOSPITAL NAME

2b. ______________________________
Address/Street

3b. ______________________________
City/State/Zip

4b. ______________________________ 5b. From: ____________ To: ____________
Status of privileges *(INDICATE BY USING KEY)* Dates attended (month/year)
*If CO-Admitting status, list other admitting physician(s).* ______________________________

6b. Any past or present restriction of privileges? Yes ______ No ______ *(IF YES, EXPLAIN)*

## IV (B). HOSPITAL AFFILIATIONS: OTHER (continued)

1c. ____________________
HOSPITAL NAME

2c. ____________________
Address/Street

3c. ____________________
City/State/Zip

4c. ____________________ 5c. From: ______ To: ______
Status of privileges *(INDICATE BY USING KEY)* Dates affiliated (month/year)
*If CO-Admitting status, list other admitting physician(s).* ____________________

## IV (C). OTHER PRACTICE AFFILIATIONS (e.g. HMOs, PPOs, IPAs, PHOs, etc.) FOR HOSPITAL CREDENTIALING ONLY

Attach additional pages if necessary.

1a. ____________________
Institution/Organization name

2a. ____________________
Address/Street

3a. ____________________
City/State/Zip

4a. ____________________ 5a. From: ______ To: ______
Type of affiliation Dates affiliated (month/year)

1b. ____________________
Institution/Organization name

2b. ____________________
Address/Street

3b. ____________________
City/State/Zip

4b. ____________________ 5b. From: ______ To: ______
Type of affiliation Dates affiliated (month/year)

1c. ____________________
Institution/Organization name

2c. ____________________
Address/Street

3c. ____________________
City/State/Zip

4c. ____________________ 5c. From: ______ To: ______
Type of affiliation Dates affiliated (month/year)

1d. ____________________
HOSPITAL NAME

2d. ____________________
Address/Street

3d. ____________________
City/State/Zip

4d. ____________________ 5d. From: ______ To: ______
Type of affiliation Dates affiliated (month/year)

1e. ____________________
HOSPITAL NAME

2e. ____________________
Address/Street

3e. ____________________
City/State/Zip

4e. ____________________ 5e. From: To:
Type of affiliation Dates affiliated (month/year)

# V. PRACTICE SPECIALTY

Attach copy of certificate(s). If not applicable to your profession/specialty, complete with N/A.

1. ______________________ PRIMARY SPECIALTY/BOARD CERTIFICATION
2. ______________________ Certification number
3. ______________________ Name of board
4. ______________________ Date of certification
5. ______________________ Expiration date
6. ______________________ Date of recertification (if applicable)
7. ______________________ If not certified, indicate current status and/or date intending to sit for boards.
8. ______________________ SECONDARY SPECIALTY / BOARD CERTIFICATION
9. ______________________ Certification number
10. ______________________ Name of board
11. ______________________ Date of certification
12. ______________________ Expiration date
13. ______________________ Date of recertification (if applicable)
14. ______________________ If not certified, indicate current status and/or date intending to sit for boards.

# VI. WORK/PRACTICE HISTORY

List chronologically all employment, including self-employment, for the last ten years. For any gap in chronology, explain on a separate sheet. Leave no time period unaccounted for within the last ten years, excluding previously stated training.
Attach additional sheets if necessary.

1a. ______________________ NAME OF PREVIOUS PRACTICE
2a. ______________________ Address/Street
3a. ______________________ City/State/Zip
4a. ______________________ Phone number
5a. ______________________ Title or professional occupation
6a. From: To: Dates of employment (month/year)

1b. ______________________ NAME OF PREVIOUS PRACTICE
2b. ______________________ Address/Street
3b. ______________________ City/State/Zip
4b. ______________________ Phone number
5b. ______________________ Title or professional occupation
6b. From: To: Dates of employment (month/year)

1c. ______________________ NAME OF PREVIOUS PRACTICE
2c. ______________________ Address/Street
3c. ______________________ City/State/Zip
4c. ______________________ Phone number
5c. ______________________ Title or professional occupation
6c. From: To: Dates of employment (month/year)

1d. ______________________ NAME OF PREVIOUS PRACTICE
2d. ______________________ Address/Street
3d. ______________________ City/State/Zip
4d. ______________________ Phone number
5d. ______________________ Title or professional occupation
6d. From: To: Dates of employment (month/year)

## VII. PROFESSIONAL CERTIFICATES/LICENSE NUMBERS

List all states in which you have held or currently hold a license to practice your profession. Please attach copies.

1. ______ License/Certification/Registration number; licensing state
2. ______ Expiration date
3. ______ Other license/Certification/Registration number; licensing state
4. ______ Expiration date
5. ______ Other license/Certification/Registration number; licensing state
6. ______ Expiration date
7. ______ Federal Drug Enforcement Agency (DEA) number(s)
8. ______ Expiration date(s)
9. ______ CDS certification number (BNDD number for Missouri)
10. ______ Expiration date
11. ______ Medicare/Unique Provider ID Number (UPIN)
12. ______ National Provider Identifier (NPI) number
13. ______ State Medicaid number(s); licensing state(s)
14. ______ ECFMG number

## VIII. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Please attach a copy of your current certificate(s) or declaration(s) of insurance, including HCSF for Kansas practitioners.

1a. ______ **CURRENT CARRIER NAME**

2a. ______ Address/Street

3a. ______ City/State/Zip

4a. ______ Phone number

5a. ______ Policy number

6a. From: ______ To: ______ Dates of coverage (month/year)

7. Indicate coverage type: Claims based ______ Occurrence based ______

8. Policy limits: Per occurrence $ ______ Aggregate $ ______

Prior carriers within the last ten years. Attach additional sheets if necessary.

1b. ______ PREVIOUS CARRIER NAME

2b. ______ Address/Street

3b. ______ City/State/Zip

4b. ______ Phone number

5b. ______ Policy number

6b. From: ______ To: ______ Dates of coverage (month/year)

1c. ______ PREVIOUS CARRIER NAME

2c. ______ Address/Street

3c. ______ City/State/Zip

4c. ______ Phone number

5c. ______ Policy number

6c. From: ______ To: ______ Dates of coverage (month/year)

1d. ______ PREVIOUS CARRIER NAME

2d. ______ Address/Street

3d. ______ City/State/Zip

4d. ______ Phone number

5d. ______ Policy number

6d. From: ______ To: ______ Dates of coverage (month/year)

# IX. MALPRACTICE CLAIMS HISTORY

Are you currently or have you within the last ten years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial or settled to avoid a lawsuit? Yes _____ No _____ If yes, answer the following questions for EACH such claim. Duplicate this page as necessary.

1. ______________________ Patient name
2. ______________________ Plaintiff name, if other than patient
3. ______________________ Your involvement in the case (attending, consulting, etc.)
4. ______________________ Date of occurrence (month/day/year)
5. ______________________ Your status in the case (primary defendant, co-defendant, other)
6. ______________________ Date claim was filed (month/day/year)
7. ______________________ Professional liability carrier involved
8. ______________________ Carrier's phone number
9. ______________________ Policy number
10. ______________________ Additional defendants
11. Describe the allegations against you: ______________________
12. Describe the alleged injury to the patient: ______________________
13. Claimant/Plaintiff filed suit in court? Yes _____ No _____
14. ______________________ State court case number
15. ______________________ State
16. ______________________ County/Parish
17. ______________________ Federal court (US District Court) case number
18. ______________________ District
19. Present status of claim: Open _____ Closed _____ Pending _____

**If PENDING, DO NOT Complete the Rest of This Page EXCEPT For Signature and Date.**

20. If closed, indicate the method of resolution:

| | | |
|---|---|---|
| _____ | Dismissed | Date: __________ |
| _____ | Settled (With Prejudice) | Date: __________ |
| _____ | Settled (Without Prejudice) | Date: __________ |
| _____ | Judgment for Defendant(s) | Date: __________ |
| _____ | Judgment for Plaintiff(s) | Date: __________ |
| _____ | Other | Date: __________ |

21. ______________________ Settlement amount paid on your behalf (if any)
22. Additional information/explanation:
(patient condition and diagnosis at time of incident, description of treatment, subsequent patient outcome, etc.)

______________________ Signature

______________________ Date (month/day/year)

## X. ADDITIONAL INFORMATION

**Please answer the following questions by circling "Y" (Yes) or "N" (No).**
**Please provide an explanation for any "Yes" responses on a separate page.**

| # | Question | Y | N | N/A |
|---|---|---|---|---|
| 1. | Have any of your board certifications ever been suspended, revoked, not renewed, denied renewal, or voluntarily surrendered? | Y | N | N/A |
| 2. | Have you ever been named as a defendant in any criminal case? | Y | N | N/A |
| 3. | Have you ever been convicted, pled guilty, or pled nolo contendere to a felony or any offense reasonably related to your qualifications, functions, or duties as a medical professional, or any offense an essential element of which is fraud, dishonesty, or an act of violence? | Y | N | N/A |
| 4. | Has your malpractice insurance ever been canceled, suspended, not renewed, special rated, or restricted by the exclusion of any specific procedures from coverage? | Y | N | N/A |
| 5. | Have you ever been denied participation, suspended from, or denied renewal from the Medicare or Medicaid program, or had participation status modified? | Y | N | N/A |
| 6. | Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order, not renewed, denied renewal, or has probation ever been invoked? | Y | N | N/A |
| 7. | Has your federal or state controlled substance license ever been suspended, revoked, voluntarily surrendered, not renewed, denied renewal, or has probation ever been invoked? | Y | N | N/A |
| 8. | Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied renewal, or has probation ever been invoked? | Y | N | N/A |
| 9. | Within the last five years, have you ever been a participating provider of another HMO, PPO, PHO, or MSO, etc. with which you are not affiliated at this time? | Y | N | N/A |
| 10. | Have you ever received sanctions from a regulatory agency (e.g. CLIA, OSHA)? | Y | N | N/A |
| 11. | Has any information on you ever been reported to the National Practitioner Data Bank? | Y | N | N/A |
| 12. | Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means use of controlled substances which are obtained illegally, as well as use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner.) | Y | N | N/A |
| 13. | Within the last five years, have you ever been reprimanded or disciplined in any manner by any state licensing authority or other professional board or peer review committee for conduct related to the use of alcohol or the use of any drug? | Y | N | N/A |
| 14. | Have you discontinued practice for any reason (other than for routine vacation) for one month (30 days) or more? | Y | N | N/A |
| 15. | Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or suppliers? | Y | N | N/A |

If so, please provide the following information, attaching additional copies as necessary:

(a) ______________________ Organization name

(b) ______________________ Type of organization

(c) ______________________ Address/Street

(d) ______________________ City/State/Zip

(e) ______________________ Phone number

(f) ______________________ Federal tax ID#

(g) ______________________ Percent of business owned/invested by applicant

(h) ______________________ Nature of business interest (owner, partner, investor)

# XI. ADDITIONAL DOCUMENTATION/ATTACHMENTS

**Please attach copies of the following documents (if specifically requested):**

1. W-9 form for each entity the applicant expects will receive payments or reimbursements.
2. Collaborative practice and/or physician assistant agreement(s).
3. A list of other members of your practice, their specialties, and coverage arrangements.
4. Education Council for Foreign Medical Graduates (ECFMG) certificate.
5. Board certification certificate(s).
6. Copies of professional diplomas, internship, residency, and fellowship certificates, as applicable.
7. Current state licenses (for all states practicing).
8. Federal DEA certificate.
9. State controlled substance certificate(s) for all states practicing (i.e. BNDD for Missouri).
10. Current certificate(s) or declaration(s) of insurance, including HCSF for Kansas practitioners.
11. Curriculum Vitae (if required by health carrier).
12. Professional references (if required by health carrier).
13. Signed copy of an affirmation and release of information document (attestation page) as stipulated by the health carrier to which the applicant is seeking to become a participating provider.
14. Attach a copy of all postgraduate (CME) activities which you have attended and for which you have received credit in the past two years.
15. A list of societies of which you are currently a member.
16. United States Military discharge papers/DD214 if discharged from U.S. Military or status if currently serving.
17. CLIA waiver number and identification number (or copy of certificate).
18. Provide a statement regarding the reasons for any inability to perform the essential functions, with or without reasonable accommodation, for the practice in which you are seeking to become a participating provider.

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

# ADDITIONAL ADDRESS INFORMATION

Complete this form if additional addresses are needed other than indicated on Page 2 of the application.

**PROVIDER NAME** ______________________________________________
**This provider name must match Box 1 of the Provider Agreement.**

**SERVICE LOCATION ADDRESS (This is the practice or physical site location.)**
**This provider address must match Box 2 of the Provider Agreement.**

Street ______________________________________________

City/State/Zip ______________________________________________

Phone # ____________________ Ext _________ Fax # ____________________

**PAY TO NAME** ______________________________________________
**This pay to name must match Box 3 of the Provider Agreement.**

**PAY TO ADDRESS (This is the address to which payments will be mailed.)**
**This pay to address must match Box 4 of the Provider Agreement.**

Street ______________________________________________

City/State/Zip ______________________________________________

Phone # ____________________ Ext _________ Fax # ____________________

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

Street ______________________________________________

City/State/Zip ______________________________________________

Phone # ____________________Ext _________ Fax # ____________________

**HOME OFFICE ADDRESS (This is the address of the <u>business home office</u>.)**

Street ______________________________________________

City/State/Zip ______________________________________________

Phone # ____________________Ext _________ Fax # ____________________

# TYPE & SPECIALTY - STANDARDIZED

***All specialties listed require proof of liability insurance.***

**09 – ADVANCED PRACTICE NURSE**
Individual Verification Wet Form, Copy of ANCC ID card, Collaborating Physician Statement.

**_____ 094 Certified Registered Nurse Anesthetist (CRNA)**
Kansas providers: ARNP and CRNA licenses. Out-of-state providers: CCNA or recertification license. Both: individual verification.

**_____ 093 Advanced Registered Nurse Practitioner (ARNP)**
ATTACH A COPY OF A CURRENT LICENSE.

**_____ 095 Certified Nurse Midwife (CNM)**
ATTACH A COPY OF A CURRENT LICENSE.

**_____ 096 Psychiatric Nurse Practitioner**
ATTACH A COPY OF A CURRENT LICENSE.
Optum Clinical Expertise Checklist

**_____ 125 Home-Based Family Therapy (HBFT)**
ATTACH A COPY OF A CURRENT LICENSE

**_____ 400 Screening, Brief Intervention, and Referral (SBIRT)**
NEED SBIRT CEU AND/OR CERTIFICATE OF COMPLETION, DOCUMENTING A SCORE OF 70% OR GREATER.

**10 - MID-LEVEL PRACTITIONER**
ATTACH A COPY OF CURRENT LICENSE.
Curriculum vitae (list current position and a continuous five-year work history, including month and year); physician's board certification: evidence of current board certification by American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Physician Specialists (ABPS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABOPPM), Royal College of Physicians and Surgeons of Glasgow (RCPSG), The College of Family Physicians Canada (CFPC), or Royal Colleges of Physicians and Surgeons of Canada (RCPCS); Collaborating Physician Statement, and CSR certificate.

**_____ 100 Physician Assistant (PA)**

**_____ 400 Screening, Brief Intervention, and Referral (SBIRT)**
*NEED SBIRT CEU AND/OR CERTIFICATE OF COMPLETION, DOCUMENTING A SCORE OF 70% OR GREATER.*

**11 – MENTAL HEALTH PROVIDER**
ATTACH A COPY OF CURRENT LICENSE FROM THE KANSAS BEHAVIORAL SCIENCE REGULATORY BOARD OR EQUIVALENT FOR BORDER CITIES (CITIES WITHIN 50 MILES OF THE KANSAS BORDER).

**_____ 112 Psychologist: Level of Education ___PHD ___PSYD**

**_____ 125 Home-Based Family Therapy (HBFT)**
ATTACH A COPY OF A CURRENT LICENSE

**_____ 400 Screening, Brief Intervention, and Referral (SBIRT)**
NEED SBIRT CEU AND/OR CERTIFICATE OF COMPLETION, DOUMENTING A SCORE OF 70% OR GREATER.

**14 – PODIATRIST**
ATTACH A COPY OF CURRENT LICENSE.
Curriculum vitae (list current position and a continuous five-year work history, including month and year), Copy of Declaration Sheet and/or Certificate of Insurance (Professional Malpractice and Comprehensive General Liability Insurance Policies).

**_____ 140 Podiatrist (DPM)**

**_____ 400 Screening, Brief Intervention, and Referral (SBIRT)**
NEED SBIRT CEU AND/OR CERTIFICATE OF COMPLETION, DOCUMENTING A SCORE OF 70% OR GREATER.

**15 – CHIROPRACTOR**
ATTACH A COPY OF CURRENT LICENSE Curriculum vitae (list current position and a continuous five-year work history, including month and year), Copy of Declaration Sheet and/or Certificate of Insurance (Professional Malpractice and Comprehensive General Liability Insurance Policies).

**_____ 150 Chiropractor (DC)**

**_____ 400 Screening, Brief Intervention, and Referral (SBIRT)**
NEED SBIRT CEU AND/OR CERTIFICATE OF COMPLETION, DOCUMENTING A SCORE OF 70% OR GREATER.

# PHYSICIAN (MD)/OSTEOPATH (DO)

ENCLOSE A COPY OF A CURRENT LICENSE, CURRENT PROOF OF LIABILITY INSURANCE, CURRICULUM VITAE (LIST CURRENT POSITION AND A CONTINUOUS FIVE-YEAR WORK HISTORY, INCLUDING MONTH AND YEAR), AND CSR CERTIFICATE.

_____ 125 Home-Based Family Therapy (HBFT)

_____ 348 Addiction Medicine

_____ 310 Allergist

_____ 311 Anesthesiologist

_____ 312 Cardiologist

_____ 313 Cardiovascular Surgeon

_____ 314 Dermatologist

_____ 315 Emergency Medicine Practitioner

_____ 349 Exempt License Physician

*Must be licensed by the Kansas Board of Healing Arts with an **exempt** license type.*

_____ 316 Family Practitioner

_____ 317 Gastroenterology

_____ 344 General Internist

_____ 345 General Pediatrician

_____ 318 General Practitioner

_____ 319 General Surgeon

_____ 335 Maternal Fetal Medicine

_____ 323 Neonatologist

_____ 324 Nephrologist

_____ 325 Neurological Surgeon

_____ 326 Neurologist

_____ 328 Obstetrician/Gynecologist

_____ 329 Oncologist

_____ 330 Ophthalmologist

_____ 331 Orthopedic Surgeon

_____ 332 Otologist, Laryngologist, Rhinologist

_____ 333 Pathologist

_____ 336 Physical Medicine & Rehab Practitioner

_____ 337 Plastic Surgeon

_____ 338 Proctologist

_____ 339 Psychiatrist

_____ 340 Pulmonary Disease Specialist

_____ 341 Radiologist

_____ 343 Urologist

_____ 350 Preventative Medicine

_____ 400 Screening, Brief Intervention, and Referral (SBIRT)

*Need SBIRT CEU and/or certificate of completion, documenting a score of 70% or greater.*

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# PROVIDER BINDER

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

**TYPE OF PRACTICE ORGANIZATION:**

_____INDIVIDUAL PRACTICE _____PARTNERSHIP _____CORPORATION

_____CHARITABLE _____PRIVATELY OWNED _____LLC

_____HOSPITAL-BASED PHYSICIAN _____MUNICIPAL OR STATE-OWNED _____OTHER

WAS THE PREVIOUS OWNER ENROLLED IN THE KANSAS MEDICAID/MEDIKAN PROGRAM?
_____YES _____NO

PREVIOUS OWNER'S MEDICAID/MEDIKAN PROVIDER NAME ________________________________________

PREVIOUS OWNER'S MEDICAID/MEDIKAN PROVIDER NUMBER ______________________________________

DATE SERVICES WILL FIRST BE PROVIDED TO MEDICAID/MEDIKAN BENEFICIARIES ___________________

MEDICARE PROVIDER NUMBER FOR THIS APPLICANT AT THIS LOCATION ____________________________

CLIA NUMBER FOR THIS LOCATION ____________________________________________________________

CONTACT PERSON FOR QUESTIONS PERTAINING TO THIS APPLICATION ____________________________

CONTACT PERSON PHONE NUMBER ____________________________________________________________

**Kansas Department of Health and Environment, Division of Health Care Finance**
**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**

By: __________________________________________________________

Title: ________________________________________________________

Date: ________________________________________________________

**Kansas Medical Assistance Program**
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# PROVIDER ATTESTATION

This letter of attestation is being provided on behalf of the following individual or business entity.

Individual/business name ____________________

Physical address ____________________

____________________

Telephone number ____________________

Contact person ____________________

Type of building for business

☐ Free-standing building

☐ Storefront (a store or other establishment that has frontage on a street or thoroughfare)

☐ Professional office building with multiple office suites

☐ Other (please specify)

Business hours of operation ____________________

Type of services provided (such as medical, pharmaceutical, equipment/medical supplier, personal care)

____________________

____________________

Is the place of business closed for lunch and/or deliveries? Yes ☐ No ☐

Is the place of business ADA accessible? Yes ☐ No ☐

Is there a sign indicating the presence of the business clearly visible at the entrance? Yes ☐ No ☐

The provider agrees to comply with all state and federal laws, regulation, and professional standards applicable to services and professional activities provided to KMAP beneficiaries.

Under penalty of perjury, I certify by my signature the information provided is accurate. I also certify I am a duly authorized representative of the individual or business entity named above.

Provider signature ____________________

Printed name ____________________

Title ____________________

Date ____________________

**Kansas Medical Assistance Program**
P O Box 3571
Topeka, KS 66601-3571
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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.<br>*NOTE: Designate association to each person listed in question #1 by using 1A, 1B, 1C, etc.*<br>*42 CFR 455.104(b)(3)* | Yes ☐<br>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?<br>*NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.* | Yes ☐<br>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***.<br>*42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)* | Yes ☐<br>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.<br>*Note: Designate association to **subcontractor** listed above by using 5A, 5B, 5C, etc.*<br>*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***.<br>*42 CFR 455.105(b)(2)* | | Yes ☐<br>No ☐ |
|---|---|---|
| Name | Address | Description of Business Transaction |
| | | |
| | | |
| | | |
| | | |

| 7. Provide the following information on all ***managing employees*** of the provider entity.<br>*NOTE: This question cannot be blank.*<br>*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.<br>*NOTE: Designate association to each person listed in this question by using 1A, 1B, 5A, 5B, etc.* | | | | | Yes ☐<br>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.<br>*42 CFR 455.106(a)(2)* | | Yes ☐<br>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:<br>• Criminal Conviction • Administrative Sanction • Program Exclusion<br>• Suspension of Payment • Civil Monetary Penalty • Assessment<br>• Program Debarment • Criminal Fine • Restitution Order<br>• Pending Civil Judgment • Pending Criminal Judgment<br>• Judgment Pending Under False Claims Act<br>If yes, provide the following information below and attach copy of the adverse legal action notification(s). | | | | Yes ☐<br>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:<br>• Criminal Conviction • Administrative Sanction<br>• Program Exclusion • Suspension of payment<br>• Civil Monetary Penalty • Assessment<br>• Program Debarment<br>If yes, provide the following information below and attach copy of the adverse legal action notification(s). | | | | Yes ☐<br>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 ☐<br>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.<br>*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 <u>before</u> 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
Department of Health
and Environment
Division of Health Care Finance

DECEMBER 2018

KMAP GENERAL BULLETIN 18250

# Provider Application Fee Update

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications, re-enrollments (revalidations), and reactivations.

The following providers are exempt from the application fee:

- Individual providers, nonphysician practitioners, or groups
- Providers who are enrolled with Medicare
- Providers who paid the application fee to either Medicare or another state Medicaid plan
- Applicable provider types indicated in the matrix on the following page

**The application fee for 2019 will be $586. Payment must be made in the form of a check or money order to the State of Kansas – Medicaid. This amount will go into effect for any application received on and after January 1, 2019.**

The enrollment fee must be paid for each provider type. The matrix on the following page indicates the application fee requirements by provider type.

***Note:*** In order to waive the application fee, enrollment or payment with Medicare must be verified through PECOS by the fiscal agent.

If an application fee is required and the appropriate payment is not included or is not in an acceptable format, the paperwork will be returned to the provider requesting proper payment.

The application fee will not be refunded in the event the application or revalidation is denied.

**KMAP**
Kansas Medical Assistance Program

- Bulletins
- Manuals
- Forms

Customer Service

- 1-800-933-6593
- *7:30 a.m. - 5:30 p.m. Monday - Friday*

DXC Technology is the fiscal agent of KMAP.

| | Owe an application fee? | |
|---|---|---|
| **Provider Type** | ***Individual*** | ***Business*** |
| 1 Hospital | NA | Yes |
| 2 Ambulatory Surgical Center | NA | Yes |
| 3 Custodial Care Facility | NA | Yes |
| 4 Rehabilitation Facility | NA | Yes |
| 5 Home Health Agency | NA | Yes |
| 6 Hospice | NA | Yes |
| 7 Capitation Provider | NA | No |
| 8 Clinic Maternity/Early Childhood Intervention/Family Planning Clinic | NA | No |
| 8 Clinic RHC/FQHC | NA | Yes |
| 9 Advance Practice Nurse | No | No |
| 10 Mid-level Practitioner | No | No |
| 11 Mental Health Provider | No | Yes (business) No (group) |
| 12 Local Education Agency | NA | Yes |
| 13 Public Health Agency | NA | No |
| 14 Podiatrist | No | No |
| 15 Chiropractor | No | No |
| 17 Therapist | No | No |
| 18 Optometrist | No | No |
| 19 Optician | No | No |
| 20 Audiologist | No | No |
| 21 Targeted Case Management | No | Yes |
| 22 Hearing Aid Dealer | NA | Yes |
| 23 Nutritionist | No | No |
| 24 Pharmacy | NA | Yes |
| 25 Durable Medical Equipment | NA | Yes |
| 26 Transportation Provider | No | Yes |
| 27 Dentist | No | No |
| 28 Laboratory | NA | Yes |
| 29 X-Ray Clinic | NA | Yes |
| 30 Renal Dialysis Center | NA | Yes |
| 31 Physician | No | No |
| 42 Teaching Institution | NA | Yes |
| 45 QMB | No | No |
| 53 Head Start Facility | NA | Yes |
| 54 Screening Providers | NA | Yes |
| 55 Home Community Based Services | No | Yes |
| 56 WORK | No | No (agency or nonagency) |
| 70 Data Access Entity | No | No |

**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.)