



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SUPPLIER APPLICATION CHECKLIST

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.

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.

Specialty Listing: A specialty must be marked.

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.

Original signature and date are required.

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, a claim showing services were rendered on or before the requested effective date must be attached.

Current license

An expired license will not be accepted.

The license must be from the state in which the provider will be practicing.

W-9

A copy of the W-9 is required.

Durable Medical Equipment Supplier Attestation Form

If you are enrolling as a durable medical equipment (DME) supplier, you must attach this form. Original signature and date are required.

Application fee, if applicable

Refer to General Bulletin 11043 attached to this application.



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

Dear prospective provider:

Thank you for your interest in the Kansas Medical Assistance Program (KMAP).

The application materials listed below must be completed and returned to the fiscal agent so your enrollment can be processed. Submission of incomplete application materials will delay your enrollment.

- KMAP Application
- Specialty Listing
- The Ownership and Control Interest Disclosure Statement
- KMAP Provider Agreement
- A copy of your current license (if required)

In order to facilitate the assignment of a provider number, please 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 exist:

- 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, please 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, determines that the services are medically necessary. Failure to meet either of the above situations may result in denial of your claim.

If either situation presently exists or may exist, then please complete the enclosed application forms and be sure that all information requested is provided.

If you have questions concerning enrollment, please contact Provider Enrollment at P.O. Box 3571, Topeka, Kansas 66601 or by telephone at 785- 274-5914, between 8:00 a.m. and 4:30 p.m., Monday through Friday. If you have any questions regarding prior authorization, please call 1-800-285-4978.

Sincerely,

KMAP Provider Enrollment



November 2011

Provider Bulletin Number 11152

General Providers

Application Fee Update

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications and all applications submitted as part of the provider revalidation. The following providers are exempt from the application fee:

- Individual providers or nonphysician practitioners
- Providers who enrolled with Medicare or another state Medicaid plan after March 25, 2011
- Providers who paid the application fee to either Medicare or another state Medicaid plan

The application fee for 2012 will be \$523.00. Payment must be made in the form of a bank-certified check or money order made out to the State of Kansas – Medicaid. This amount will go into effect for any application received on and after January 1, 2012.

Note: In order to waive the application fee, proof of enrollment or revalidation in Medicare or another state Medicaid plan is required and must be dated after March 25, 2011. For Medicare providers, a copy of your most recent Medicare explanation of benefits (EOB) is also acceptable proof of active enrollment. Proof of payment is a receipt or formal notification from Medicare or the other state Medicaid plan specifically indicating payment of the application fee.

If an application is received and deemed to require an application fee and one is not attached or payment is not in an acceptable format, the entire application will be returned to the provider requesting proper payment.

Information about the Kansas Medical Assistance Program (KMAP) as well as provider manuals and other publications is available at <https://www.kmap-state-ks.us>.

If you have any questions, please contact Customer Service at 1-800-933-6593 (in-state providers) or 785-274-5990 from 8:00 a.m. until 5:00 p.m., Monday through Friday.



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

Choose One: New Enrollment Revalidation

Kansas Medical Assistance Program (KMAP) PROVIDER APPLICATION

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 the processing of your application.

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 e-mail 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:



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

TYPE OF PRACTICE ORGANIZATION:

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

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 _____
 E-MAIL 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 _____ NUMBER _____
 E-MAIL 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 _____
 E-MAIL 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 _____
 E-MAIL ADDRESS _____



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

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 e-mail 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:

<u>NAME</u>	<u>CREDENTIALS</u>	<u>KMAP PROVIDER ID</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

If additional space is needed, please use a separate sheet.

SECTION C

PROVIDER SPECIALTY/PRACTICE DATA

USING THE SPECIALTY LISTING ATTACHED, PLEASE INDICATE THE KMAP SPECIALTY BEING REQUESTED.

PRIMARY: _____ SECONDARY: _____

KANSAS SCHOOL DISTRICT (for physical location): _____



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

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:

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET.

NAME OF ORGANIZATION: _____

TAX IDENTIFICATION NUMBER: _____ **TELEPHONE NUMBER:** _____

STREET ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____
(nine-digit)

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)

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

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

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 Programs.

I understand that should I be enrolled as a provider of services under the Kansas Medical Assistance Programs, that it is my responsibility to notify the Kansas Medical Assistance Programs' 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 AND 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 Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

SPECIALTY LISTING – Supplier

22- HEARING AID DEALER

_____ 220 HEARING AID DEALER

24- PHARMACY

Need licenses for the pharmacy and the pharmacist in charge.

_____ 241 INSTITUTIONAL PHARMACY

_____ 240 PHARMACY

_____ 242 PHARMACY MAIL*

**Only out-of- state providers may enroll under this specialty.*

Must attach a copy of a Non-Resident Kansas Pharmacy License. Medicaid payment is limited to claims that have been reimbursed in part by third party payer only.

_____ 351 INDIAN HEALTH SERVICES (effective 08/01/2008)

25- DURABLE MEDICAL EQUIPMENT SUPPLIER (DME)

_____ 250 DME/MEDICAL SUPPLY COMPANY

Must attach DME Supplier Attestation Form.

_____ 255 VACCINE ADMINISTRATION (effective 03/01/2001)

Must attach a copy of certification from either American Pharmacists Association or Accreditation Council for Pharmacy Education.

_____ 277 ORTHOTIC PROSTHETIC

Must attach a copy of certification from either American Orthotic and Prosthetic Association or American Board of Certification in Orthotic and Prosthetic.

26- AMBULANCE SERVICE

Need license and a copy of the Medicare approval letter.

_____ 261 AMBULANCE - AIR

_____ 260 AMBULANCE

28- INDEPENDENT LABORATORY

Need CLIA certificate and a copy of the Medicare approval letter.

_____ 280 INDEPENDENT LABORATORY

_____ 283 PATHOLOGY LAB

29- INDEPENDENT X-RAY SERVICE

Need a copy of the radiologist license.

_____ 291 MOBILE X-RAY CLINIC

_____ 293 DIAGNOSTIC X-RAY

Durable Medical Equipment Supplier Attestation Form

This letter of attestation is being provided on behalf of the following business entity:

Business Name/Address: _____

Telephone Number: _____
Contact Person: _____

1. Is the place of business presence indicated by a storefront, a display of items and customer service staff available during business hours? Y N

2. What hours is the place of business open?
 - a. What days of the week is the place of business open?
 - b. Is the place of business closed for lunch and/or deliveries? Y N
 - c. Is a customer service representative always available during business hours? Y N

3. Is the place of business ADA accessible? Y N

4. Is the place of business able to handle a walk-in customer? Y N
 - a. Are appointments required? Y N

5. Is there a sign indicating the presence of the business clearly visible at the entrance? Y N
 - a. Are the office hours posted at the business entrance? Y N
 - b. Is a 24-hour contact telephone number posted at the business entrance? Y N

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 business entity named above.

Provider Signature: _____
Printed Name: _____
Title: _____
Date: _____

Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

DME PROVIDERS ONLY

Supplies or equipment to be furnished and where the supplies are located:

How does the patient know to contact you for services?

DME requirements:

- Must have a consumer service representative who is available 24 hours per day
- Business in Kansas or a border city which is accessible in accordance with the appropriate ADA guidelines
- Open to the general public between the hours of 9:00 am. and 5:00 p.m.

(Pharmacies located in Kansas or a border city that have a Medicaid provider number may enroll as a DME provider even if no storefront is present.)

Do you have a storefront that is accessible to the public? Yes No

Is this facility currently enrolled as a pharmacy in the Kansas Medicaid program? Yes No

If yes, pharmacy KMAP ID and NPI: _____

NOTE: ALL INFORMATION WILL BE VERIFIED THROUGH AN ON-SITE VISIT.

DATE SUPPLIES WILL BE, OR WERE PROVIDED TO KMAP BENEFICIARIES _____

AUTHORIZED SIGNATURE _____ **DATE** _____

Provider Compliance Attestation Form

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

Individual/Business Name and _____
Physical Address:

Telephone Number:

Contact Person:

1. Please indicate the type of building in which the business resides:
 - a. Free-standing building
 - b. Storefront (a store or other establishment that has frontage on a street or thoroughfare)
 - c. Professional office building with multiple office suites
 - d. Other (please specify): _____
2. Please indicate the business hours of operation: _____
3. What type of services are provided (medical, pharmaceutical, equipment/medical supplier, personal care, etc)? _____
4. Is the place of business closed for lunch and/or deliveries? Y N
5. Is the place of business ADA accessible? Y N
6. Is there a sign indicating the presence of the business clearly visible at the entrance? Y N

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

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

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: _____



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 _____
Manager, Kansas Medical Assistance Program Provider Enrollment

Date _____



STATE OF KANSAS

Disclosure of Ownership and Control Interest Statement

Name of Entity/Individual	EIN/SSN	Date of Birth (if ind.)	NPI	Taxonomy
Address		City/ST		Zip Code

Questions 1 – 3 to be answered by fiscal agents and by all providers EXCEPT individual practitioners. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

1. Provide the following information for each person (individual or corporation) with 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.

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

1.a. For each corporation above, please provide the following:
NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.

Tax Identification Number	Primary Business Address

1.b. For each corporation above, please provide the following:
NOTE: Designate the corporate entity in question #1 by using 1.A., 1.B., 1.C., etc.

Every Business Location	Every P.O. Box Address

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

Yes
 No

Name	Relationship

3. Does any person named in question #1 have an ownership or control interest in any other Medicaid provider or in any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or entity.
NOTE: Designate relationship to each person listed in question #1 by using 1.A., 1.B., 1.C., etc.

Yes
 No

Name	Address	Tax Identification Number

Questions 4 – 14 to be answered by ALL providers. If more space is needed, please provide the information on a separate piece of paper and attach to this document.

4. Has the provider, 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, please provide the following information below.

NOTE: A managing employee is 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.”

Yes
 No

Name	Description

5. Has the provider 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.

Yes
 No

Name	Address	Date of Birth (if individual)	Social Security Number (if individual)
A.			
B.			
C.			
D.			
E.			

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

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

Name	Address	Date of Birth	Social Security Number

6. Has the provider 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.

Yes
No

Name	Address	Description of Business Transaction

7. Please provide the following information on all managing employees of the provider.

NOTE: Please see question #4 for the definition of a managing employee.

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

8. Have <u>any</u> of the individuals listed in questions #1 - 7 ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, please provide the following information below.			Yes <input type="checkbox"/>
			No <input type="checkbox"/>
Name	Program	State	

8.a. Have any of the individuals in question #8 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, please provide the following information below.			Yes <input type="checkbox"/>
			No <input type="checkbox"/>
Name	Program	State	

8.b. Do any of the individuals listed in question #8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes <input type="checkbox"/>
				No <input type="checkbox"/>
Name	Program	State	Amount of Debt	

9. Does any family or household members of any of the individuals listed in questions #1 - 8 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, please provide the following information below and attach documentation of the arrangements made to repay the debt.

NOTE: Designate relationship to each person listed in this question by using 1.A., 1.B., 5.A, 5.B., etc.

Yes
No

Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt

10. Have any of the individuals listed in questions #1 – 9 had any of the following healthcare related adverse legal actions imposed by Medicaid or any other Federal agency or program:

- Criminal Conviction
- Program Exclusion
- Civil Monetary Penalty
- Program Debarment
- Restitution Order
- Pending Criminal Judgment
- Administrative Sanction
- Suspension of Payment
- Assessment
- Criminal Fine
- Pending Civil Judgment
- Judgment Pending Under False Claims Act

If yes, please provide the following information below and attach copy of the adverse legal action notification(s).

Yes
No

Name	Program	State	Action

<p>11. Have <u>any</u> of the individuals listed in questions #1 – 10 had any of the following non-healthcare related adverse legal actions:</p> <ul style="list-style-type: none"> • Criminal Conviction • Program Exclusion • Civil Monetary Penalty • Program Debarment • Administrative Sanction • Suspension of payment • Assessment <p>If yes, please provide the following information below and attach copy of the adverse legal action notification(s).</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
---	---

Name	Program	State	Action

<p>12. Is the provider part of a provider or entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, please provide the following below.</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
---	---

Name of Provider or Entity	Address of Provider or Entity	Tax Identification Number of Provider or Entity

<p>13. Please provide the following information for the contact person for audit purposes.</p>
--

Name	Address	Phone Number	Title

<p>14. Please provide the address for the physical location of the records required to be kept under K.A.R. 30-5-59. P.O. Boxes and drop boxes are not acceptable.</p>
--

Address	City/ST	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 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, if different than the Applicant _____

Name of Authorized Representative (Typed) _____

Signature of Authorized Representative _____

Title _____

Date _____



Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

Submit Kansas Medical Assistance Program Claims Electronically

Benefits to submitting claims electronically include:

- Claims adjudicate within hours
- 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 hours when submitting 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. Call 1-800-933-6593 for details.

Other electronic claims solutions include:

Third-party software – A provider can select a software that meets his or her needs. An EDI application and authorization test are required before submitting claims for payment. The electronic claims clearinghouse (intermediary) must be authorized with the fiscal agent. Call 1-800-933-6593 for details.

For any questions regarding electronic claims or authorization testing, please contact the EDI Help Desk at 1-800-933-6593 or by e-mail at LOC-KSXIX-EDIKMAP@external.groups.hp.com.

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

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
785-274-5990 (local) or 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.)