



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

STANDARDIZED 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
(Kansas Standardized Application, pages 1-11)**

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.

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

_____ **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.

Unless noted on the specialty page, the license must be from the state in which the provider will be practicing as indicated on page 2, question 2, of the application.

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.

_____ **HealthConnect Kansas Contract**

If you are participating as a primary care case manager (PCCM) with the HealthConnect Kansas program, you must complete a new contract when changing your KMAP provider number. Contact Managed Care at 1-866-305-5147.

_____ **Application fee, if applicable**

Refer to General Bulletin 11043 attached to this application.



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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.

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. _____
E-Mail 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 E-Mail 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, 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 (cont'd.)

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. Office Phone Number _____ 27. After Hours/Emergency Number or Procedure _____

28. Office Fax Number _____ 29. Office E-Mail Address _____

30. Office Manager _____ 31. 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, 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 (cont'd)

1c.	HOSPITAL NAME	
2c.	Address/Street	
3c.	City/State/Zip	
4c.	Status of Privileges (INDICATE BY USING KEY) If CO-Admitting Status, List Other Admitting Physician(s)	5c. From: _____ To: _____ Dates Affiliated (month/year)

**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.	Type of Affiliation	5a. From: _____ To: _____ Dates Affiliated (month/year)
1b.	Institution/Organization Name	
2b.	Address/Street	
3b.	City/State/Zip	
4b.	Type of Affiliation	5b. From: _____ To: _____ Dates Affiliated (month/year)
1c.	Institution/Organization Name	
2c.	Address/Street	
3c.	City/State/Zip	
4c.	Type of Affiliation	5c. From: _____ To: _____ Dates Affiliated (month/year)
1d.	HOSPITAL NAME	
2d.	Address/Street	
3d.	City/State/Zip	
4d.	Type of Affiliation	5d. From: _____ To: _____ Dates Affiliated (month/year)
1e.	HOSPITAL NAME	
2e.	Address/Street	
3e.	City/State/Zip	
4e.	Type of Affiliation	5e. From: _____ To: _____ 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 (10) 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 ID Number (NPI)
13. _____ State Medicaid Number(s); Licensing State(s)	14. _____ ECFMG Number

VII. 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 (10) 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 (10) 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:
(e.g. 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), “N” (No).
Please Provide an Explanation For Any “Yes” Responses on a Separate Page.**

- | | | | |
|--|---|---|-----|
| 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, etc.)? | 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. W9 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 2 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 Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

From the office of the Fiscal Agent

If necessary, complete this form with additional addresses as indicated on page two of the application.

PROVIDER NAME: _____

Provider name must match Box 1 of the Provider Agreement.

SERVICE LOCATION ADDRESS: (This is the practice or physical site location.)

Provider address must match Box 2 of the Provider Agreement.

Street: _____

City/State/Zip: _____

Phone # _____ EXT: _____ FAX #: _____

PAY TO NAME: _____

Pay to name must match Box 3 of the Provider Agreement.

PAY TO ADDRESS: (This is the address where payments will be mailed.)

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 where correspondence will be mailed.)

Street: _____

City/State/Zip: _____

Phone # _____ EXT: _____ FAX #: _____

HOME OFFICE ADDRESS: (This is the address of the business home office.)

Street: _____

City/State/Zip: _____

Phone # _____ EXT: _____ FAX #: _____



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From the office of the Fiscal Agent

GROUP NUMBER: _____
If no group number is indicated, provider will not be listed as a member of the 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 APPLICATN AT THIS LOCATION _____

CLIA NUMBER FOR THIS LOCATION _____

CONTACT PERSON FOR QUESTIONS PERTAINING TO THIS APPLICATION _____

CONTACT PERSON PHONE NUMBER _____

**The 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 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:

By: _____

Title: _____

Date: _____

Kansas Medical Assistance Program

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From the office of the Fiscal Agent

SPECIALTY LISTING - Standardized

09 – ADVANCED PRACTICE NURSE

____ 094 Certified Registered Nurse Anesthetist (CRNA)
Kansas providers need ARNP and CRNA licenses. Out-of-state providers need CCNA (Council On Certification of Nurse Anesthetists) or re-certification license.

____ 093 Advanced Registered Nurse Practitioner (ARNP)
ATTACH A COPY OF CURRENT LICENSE (required).

____ 095 Certified Nurse Midwife (CNM)
ATTACH A COPY OF CURRENT LICENSE (required).

____ 096 Psychiatric Nurse Practitioner
ATTACH A COPY OF CURRENT LICENSE (required).

10 - MID-LEVEL PRACTITIONER

ATTACH A COPY OF CURRENT LICENSE (required).

____ 100 Physician Assistant (PA)

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

14 – PODIATRIST

ATTACH A COPY OF CURRENT LICENSE (required).

____ 140 Podiatrist (DPM)

15 – CHIROPRACTOR

ATTACH A COPY OF CURRENT LICENSE (required).

____ 150 Chiropractor (DC)

PHYSICIAN (MD)/OSTEOPATH (DO)

ENCLOSE A COPY OF LICENSE.

____ 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

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

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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

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

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.			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	
13. Please provide the following information for the contact person for audit purposes.			
Name	Address	Phone Number	Title
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.			
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.)