



Connecticut Department of Social Services  
 Provider Enrollment/Re-enrollment Application and Agreement  
 School-Based Child Health Providers



Dear School-Based Child Health Provider:

The Department of Social Services (DSS) appreciates your interest in participating in the Connecticut Medical Assistance Program as a School-Based Child Health (SBCH) Provider. At this time, your provider type is required to use this paper application form.

- Please review the contents of the enclosed application carefully, completing all required sections and supplying all requested information.
- DSS requires the completed forms to be returned within 30 days.
- Incomplete applications cannot be processed and will be returned.

Contact the Provider Assistance Center at 1-800-842-8440 if you have questions about this application.

NOTE: Providers who have had no claim activity within the last 12 months will be automatically disenrolled and your provider agreement will be terminated. If this occurs, the provider must complete a new provider application in order to be considered for enrollment in the Connecticut Medical Assistance Program.

### The Application

The Application consists of Sections A through L, and includes the Provider Agreement as Section L. In order to maintain consistency with the standard DSS provider application packet while removing sections that are not relevant to SBCH providers, some of the sections have been intentionally omitted

Please complete all application sections indicated below:

- Section A: Type of Enrollment
- Section B: Demographic/Provider Specific Information
- Section C: Service Location Information  
List primary service location, home office, pay to and enrollment locations. **Note:** A P.O. Box cannot be accepted as any part of the primary service location address. Additionally, the zip +4 extension is a required field on all addresses. To obtain the last 4-digits of the zip code, a provider may access the United States Postal Service Web site at: <http://zip4.usps.com/zip4/welcome.jsp>.
- Section D: Provider Organization Information
- Section E: Provider Questionnaire  
Respond to each question in this section. Incomplete or unanswered questions will result in the application returned to you for completion.
- Section F: [Intentionally Omitted]
- Section G: [Intentionally Omitted]
- Section H: W9 Tax Information Form  
The Tax ID supplied on this form must match that supplied in Field 7 in Section B of the Application. For detailed instructions on completion of the W9 Form, please reference the IRS Web site at [www.irs.gov](http://www.irs.gov).
- Section I: [Intentionally Omitted]
- Section J: Electronic Signature Policy Compliance  
This section addresses the use of electronic signatures on medical, educational or treatment records.
- Section K: Application Certification and Signature  
This section is comprised of a certification page.
- Section L: Provider Agreement and Addendum to Provider Agreement for SBCH Providers  
Detailed instructions, as well as the agreement and the addendum themselves, can be found in this section.

**Section A and B: Type of Enrollment & Demographic Information**

Note: If additional space is needed to complete any of the fields indicated below, please submit on an additional 8 ½ x 11 inch sheet of paper.

Name of Individual Completing Application: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Section A: Please indicate if this application is for a new enrollment or re-enrollment.**

**New Enrollment**

**Re-enrollment**

All SBCH Providers are Organization Providers

**Section B: Demographic/Provider Specific Information**

1. Enrolling Provider Name	
2. Provider Type	12 Special Services
3. Provider Specialty	120
4. Primary Taxonomy*	251300000X
5. National Provider Identifier (NPI)*	
6. Federal Tax ID Number	
7. Federal Tax ID Effective Date	
8. State Tax ID (Provide number in space on right or check box to indicate no State Tax ID)	<input type="checkbox"/> _____ <input type="checkbox"/> I attest that I do not collect sales tax or do not have employees.
9. Requested Provider Effective Date	

\*This must match the data on the National Provider Plan and Enumeration System (NPPES).

<b>Section C: Service Location Information</b> Please complete all that apply. All fields are required.		
<b>Primary Service Location: List any location where services are provided.</b>		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Phone: ( ___ ) ___ - ____	
Fax #: ( ___ ) ___ - ____	TDD#: ( ___ ) ___ - ____	E-mail address:
Handicap Accessible: Y N                      Specific Accommodations or Languages Spoken:		

<b>Provider Home Office Location (Optional): If home office (i.e., headquarters) is the same as primary service location, leave blank.</b>		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Phone: ( ___ ) ___ - ____	
Fax #: ( ___ ) ___ - ____	E-mail address:	

<b>Provider Pay To Location: If pay to address is the same as primary service location, leave blank.</b>		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Phone: ( ___ ) ___ - ____	
Fax #: ( ___ ) ___ - ____	E-mail address:	

<b>Provider Enrollment Address: This location will receive all enrollment-related communications.</b>		
Address 1:	City:	
Address 2:	State:	Zip + 4:
Contact Name:	Phone: ( ___ ) ___ - ____	
Fax #: ( ___ ) ___ - ____	E-mail address:	

## Section D: Provider Organization Information

### Information About the Provider

1. Is the provider organized as a corporation? YES [ ] NO [ ]  
(Note: In general, only answer "yes" if the provider is directly governed by a board of directors other than a local or regional board of education. If "yes," please complete answer all questions and complete all portions of Section D.) **If "no," skip to the Managing Employees portion of Section D.**
2. If you answered "yes" to Question 1, please list the type of corporation (*e.g.*, nonprofit organization):
3. If you answered "yes" to Question 1, is this corporation is a subsidiary of another company? YES [ ] NO [ ] If "yes," please provide the following information:  
Name of Parent Company:  
Corporate Headquarters Location:

### Information about Corporate Officers. Please provide the information requested below for all corporate officers. If the applicant corporation is a subsidiary of another company, please provide the information about corporate officers of the applicant and the parent corporations.

Name and Title:			Applicant [ ]	Parent [ ]
Address 1:				
Address 2:				
City:		State:	Zip:	
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:	

Name and Title:			Applicant [ ]	Parent [ ]
Address 1:				
Address 2:				
City:		State:	Zip:	
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:	

Name and Title:			Applicant [ ]	Parent [ ]
Address 1:				
Address 2:				
City:		State:	Zip:	
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:	

Name and Title:			Applicant [ ]	Parent [ ]
Address 1:				
Address 2:				
City:		State:	Zip:	
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:	

If additional space is needed, please add on a separate sheet of paper.

### Members of Board of Directors

Name and Title:				
Address 1:				
Address 2:				
City:		State:	Zip:	
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:	

**Section D: Provider Organization Information, continued**

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

**ALL PROVIDERS MUST COMPLETE: Managing Employees (defined as a general manager or administrator who exercises operational or managerial control over, or who directly or indirectly conducts day-to-day operation of an entity)**

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

Name and Title:			
Address 1:			
Address 2:			
City:		State:	Zip:
Telephone: ( ___ ) ___ - ____	Social Security Number:		Date of Birth:

<b>Section E: Provider Questionnaire</b>			
For Organizations and Individual Practitioners, please answer each of the following questions. Blank responses will result in a Return To Provider letter requesting the information be completed. This will delay the processing of this enrollment/re-enrollment packet. If you believe a question is <b>Not Applicable</b> , please <b>select No</b> in the response field.			
1. Is, or was, applicant a Medicaid provider in any other state?		YES [ ] NO [ ]	If "Yes", list:
State:	National Provider Identifier:	Date:	
State:	National Provider Identifier:	Date:	
State:	National Provider Identifier:	Date:	
2. Is applicant a provider for any other federal program, e.g., MEDICARE?		YES [ ] NO [ ]	
If "Yes", list the name of the program.			
Program Name:	National Provider Identifier:		
Program Name:	National Provider Identifier:		
Program Name:	National Provider Identifier:		
3. Has the applicant ever been denied enrollment in Medicaid, Medicare or any other state or federal program?		YES [ ] NO [ ]	
If "Yes," list:			
Program Name:	Date of Denial:	Reason for Denial:	
Program Name:	Date of Denial:	Reason for Denial:	
4. Does applicant contract with any private health insurance providers?		YES [ ] NO [ ]	If "Yes", list:
Insurance Name:	Contract Number:		
Insurance Name:	Contract Number:		
Insurance Name:	Contract Number:		
5. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family or marriage?		YES [ ] NO [ ]	If "Yes", identify:
Name:	Date of Birth:	Social Security Number:	Relationship:
6. Are any owners, partners, members, officers, directors, shareholders, or managing employees of applicant related by family, marriage, ownership, membership, control, or business relationship to any other provider that is currently, or within the last 5 years, has been, enrolled in the Connecticut Medical Assistance Program?		YES [ ] NO [ ]	
If "Yes", identify that individual:			
Name:	Date of Birth:	Social Security Number:	Relationship:
7. Does applicant, and/or any owner, partner, member, officer, director, shareholder, or managing employee of provider owe money to the federal government and/or any State for Medicare and/or Medicaid involvement in the past?		YES [ ] NO [ ]	
If "Yes", identify:			
Name Debtor:	Amount Owed:	To Whom it is Owed:	Reason for Debt:

**Section E: Provider Questionnaire, continued**

8. Has applicant and/or any owner, associate, partner, member, officer, director, shareholder, or managing employee ever filed bankruptcy on behalf of a business which participated in a State or Federal Medical Assistance Program? YES [ ] NO [ ]  
If "Yes", identify:

Date Filed:	Location Filed:	Name Filed Under:	Name of Individual:	Position of Individual with Business

9. Is applicant and/or owner, partner, member, or officer, currently in bankruptcy? YES [ ] NO [ ] If "Yes", identify:

Date Filed:	Location Filed:	Name Filed Under:

10. Does the applicant and/or owner, partner, member or officer have an ownership or control interest in any other provider? YES [ ] NO [ ] If "yes", identify:

Name:

Address:

11. Has there been any disciplinary, administrative, civil, or criminal actions taken against applicant, a family member, partner, member, director, officer or managing employee in any way related to the provision of health care goods or services, including but not limited to those goods or services covered by Medicare or Medicaid? YES [ ] NO [ ]

If "Yes", please list any and all actions:

12. Is applicant a salaried employee of a hospital, clinic, or institution? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, or institution:

13. Does applicant provide contractual services to a hospital, clinic, or institution? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, or institution:

14. If you are re-enrolling, has there been a change in ownership or control of 5% or greater since your last enrollment? YES [ ] NO [ ]

If "Yes" to the question above, indicate the date of change:

Describe type of ownership change:

15. Are you a contractor for an enrolled Connecticut Medical Assistance Program Provider? YES [ ] NO [ ]

If "Yes", list provider:

16. Are you an employee of an enrolled Connecticut Medical Assistance Program Provider? YES [ ] NO [ ]

If "Yes", list provider:

**If you answered Yes to questions 15 or 16, you must complete the following additional questions:**

17. Does the provider have an address which is the same as the address of the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

18. Does the provider have a tax ID which is the same as the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

19. Are any of the staff working with the provider, such as nurses, physician assistants, or support staff, shared with or employed by the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

**Section E: Provider Questionnaire, continued**

20. Does the provider share, or have the use of, any space which belongs to the hospital, institution, group, or clinic (i.e. space which is not leased from the hospital, institution, group, or clinic)? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

21. Is there a subsidy of any type to or from the hospital, institution, group, or clinic? YES [ ] NO [ ]

If "Yes", name of the hospital, clinic, group, or institution:

**Section F: [Intentionally Omitted]**

**Section G: [Intentionally Omitted]**

## Section H: W-9 Tax Information Form

For detailed instructions on completion of the W9 Form, please reference the IRS Web site at [www.irs.gov](http://www.irs.gov).

Form <b>W-9</b> (Rev. August 2013) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer          Identification Number and Certification</b>	<b>Give Form to the          requester. Do not          send to the IRS.</b>
Print or type instructions on page 2.  See Specific instructions on page 2.	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	
	Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____	
Address (number, street, and apt. or suite no.)		Requestor's name and address (optional)
City, state, and ZIP code		
List account number(s) here (optional)		
<b>Part I Taxpayer Identification Number (TIN)</b> Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a TIN</i> on page 3. <b>Note.</b> If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.		
Social security number [ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employer identification number [ ][ ] - [ ][ ][ ][ ][ ][ ]
<b>Part II Certification</b> Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined below), and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. <b>Certification instructions.</b> You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.		
<b>Sign Here</b>	Signature of U.S. person ▶ _____	Date ▶ _____
<b>General Instructions</b> Section references are to the Internal Revenue Code unless otherwise noted. <b>Future developments.</b> The IRS has created a page on <a href="http://IRS.gov">IRS.gov</a> for information about Form W-9, at <a href="http://www.irs.gov/w9">www.irs.gov/w9</a> . Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page. <b>Purpose of Form</b> A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to: 1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued), 2. Certify that you are not subject to backup withholding, or 3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the		
withholding tax on foreign partners' share of effectively connected income, and 4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. <b>Note.</b> If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9. <b>Definition of a U.S. person.</b> For federal tax purposes, you are considered a U.S. person if you are: • An individual who is a U.S. citizen or U.S. resident alien, • A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, • An estate (other than a foreign estate), or • A domestic trust (as defined in Regulations section 301.7701-7). <b>Special rules for partnerships.</b> Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.		
Cat. No. 10231X		Form <b>W-9</b> (Rev. 8-2013)

## Section I: [Intentionally Omitted]

## **Section J: Electronic Signature Policy Compliance**

### **Conditions for DSS Acceptance of Electronic Signatures**

In order for DSS to accept electronic signatures on the Provider's medical records, treatment records or educational records, the Provider shall, at a minimum, meet the requirements that are listed below. In addition, the Provider shall have written policies governing the assignment and use of electronic signatures on medical records that reflect these requirements. The requirements are as follows:

In order to authenticate and safeguard confidentiality of electronic signatures, the Provider shall assign each User of an electronic signature ("User") at least two (2) distinct identification components, such as an identification code and a password, which, together, shall constitute a "unique code." For the purposes of this Addendum, the User's name will not suffice as a password.

Before assigning the unique code, the Provider shall verify the identity of the User.

The unique code assigned by the Provider to a User shall not be assigned to anyone else.

The Provider shall certify, in writing, that the User is the only person authorized by the Provider to use the unique code that was assigned to him or her.

Each User shall certify, in writing, that, the User will not release his/her User identification code or password to anyone, or allow anyone to access or alter information under his/her identity.

Each Provider and each User shall certify, in writing, that the electronic signature is intended to be the legally binding equivalent of the User's traditional handwritten signature.

The Provider who uses electronic signatures based upon use of identification codes in combination with passwords, as described above, shall use the following additional controls to ensure the security and integrity of each User's electronic signature:

- (a) Ensure that no two Users have the same combination of identification components (such as identification code and password);
- (b) Ensure that passwords are revised periodically, and no less often than every 60 days, except as otherwise agreed to in writing by DSS;
- (c) Follow loss management procedures to electronically de-authorize lost, stolen, missing or otherwise compromised documents or devices that bear or generate identification code or password information and use suitable, rigorous controls to issue temporary or permanent replacements;
- (d) Use safeguards to prevent the unauthorized use or attempted use of passwords and/or identification codes; and

## **Section J: Electronic Signature Policy Compliance, continued**

(e) Test or use only tested devices, such as tokens or cards that bear or generate identification code or password information to ensure that they function properly and have not been altered.

If a Provider uses electronic signatures based on two (2) components that are other than identification codes in combination with passwords, the Provider shall use the additional controls as set forth in (a) through (e) of this paragraph as applicable to those identification components.

Providers must use a secure, computer-generated, time-stamped audit trail that records independently the date and time of User entries, including actions that create, modify or delete electronic records. Record changes shall not obscure previously recorded information. Audit trail documentation shall be retained for a period at least as long as that required for the medical record and shall be available to DSS for review and copying.

**Section K: Application Certification and Signature**

**CERTIFICATION**

If I use electronic signatures, I certify that the provider’s policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures set forth in Section J above.

I further certify that, if the provider is granted status as a provider for Connecticut Medical Assistance programs, I, on behalf of the provider, expressly agree to the following: to abide by all applicable federal and state statutes, regulations, policy transmittals, and provider bulletins; to keep accurate and current records regarding the nature, scope and extent of services furnished to Medical Assistance recipients; and to furnish information pertaining to any claim for Medicaid payment, whether made by me or on my behalf, to the Connecticut Department of Social Services, the Secretary of Health and Human Services, and the offices of the Connecticut Chief State’s Attorney and the Connecticut Attorney General, or their agents, upon request. I will make such information available for inspection and/or copying, and/or will provide copies of such information, upon request.

I certify that I have legal authority to enter into contracts and agreements on behalf of the provider.

(The person signing this certification must be the same person whose signature appears on the Provider Agreement. Complete **all** items below.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Title

## Section L: Provider Agreement and Addendum to Provider Agreement

Instructions for the completion of the provider agreement can be found on the table below. The provider agreement follows these instructions.

**Please Note:** You are required to complete and sign both the Provider Agreement and the Addendum to Provider Agreement.

Field on Application	Type of Provider	Instructions for Completion
Name of Applicant field (located on first page of application)	<ul style="list-style-type: none"> <li>▪ Organization</li> </ul>	Must contain the provider's legal name and must match the name indicated in Section B, Field 1 of the Demographic/Provider Specific Information form.
Provider Entity Name field (located on the final page of the agreement)	<ul style="list-style-type: none"> <li>▪ Organization</li> </ul>	Must contain the organization's or individual practitioner's name. If you are doing business under another name, it is permissible to put that information after the organization's or individual practitioner's name.
Name of Authorized Representative field (located on the final page of the agreement)	<ul style="list-style-type: none"> <li>▪ Organization</li> </ul>	For an individual practitioner, must contain the printed name of the provider or the authorized representative in the first field. For group/clinic providers, this must be the person that is authorized to sign for the group/clinic.
Signature of Authorized Representative field (located on the final page of the agreement)	<ul style="list-style-type: none"> <li>▪ Organization</li> </ul>	For an individual practitioner, must contain the signature of the provider or the authorized representative. In the instance of an organization, this must be the person that is authorized to sign for that organization.

## Section L: Provider Agreement, continued



# STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES Division of Health Services Provider Enrollment Agreement

(Name of Applicant)

(hereinafter the "Provider") wishes to participate in the Connecticut Medical Assistance Program. For purposes of this Provider Enrollment Agreement (hereinafter the "Agreement"), the term "Connecticut Medical Assistance Program" means any and all of the health benefit programs administered by the State of Connecticut Department of Social Services (hereinafter "DSS"). The Provider represents and agrees as follows:

### **General Provider Requirements**

1. To comply continually with all enrollment requirements established under rules adopted by DSS or any successor agency, as they may be amended from time to time.
2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.
3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.
4. To furnish all information requested by DSS specified in the Provider Enrollment Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

To furnish material and/or substantial changes in information including changes in the status of Medicare, Medicaid, or other Connecticut Medical Assistance program eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.

5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.
6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; DSS identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes; documentation of dates of services and services provided; and all other information required by state and federal law.
7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d to 1320d-8, inclusive, and regulations promulgated thereto, as they may be amended from time to time, the confidentiality of a client's record, including, but not limited to:
  - a. client's name, address, and Social Security number;
  - b. medical services provided;
  - c. medical data, including diagnosis and past medical history;
  - d. any information received for verifying income eligibility; and
  - e. any information received in connection with the identification of legally liable third party resources.

Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:

- f. to other providers in connection with their treatment of the client;
- g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;
- h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;
- i. as required to obtain reimbursement from other payer sources;
- j. as otherwise required by state or federal law; and
- k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from the client's parents or legal guardian.

Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services; to DSS; and/or to the State Medicaid fraud control unit, in accordance with applicable state and federal law.

In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS.

9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 *et seq.*, to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

10. To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed or emailed to the Provider's current address or email address that is on file with DSS or its fiscal agent, or posted to the Connecticut Medical Assistance Program web site.
11. To make timely efforts to determine clients' eligibility, including verification of third-party payor resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

Provider further acknowledges the Connecticut Medical Assistance Program as payor of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417.436(d), if applicable.

## **Billing/Payment Rates**

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).
14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10.
15. To submit only those claims for goods and services that are covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:
  - a. for medically necessary goods and services;
  - b. for medically necessary goods and services actually provided to the person in whose name the claim is being made;
  - c. for compensation that Provider is legally entitled to receive; and
  - d. in compliance with DSS requirements regarding timely filing.
16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients. The Provider agrees not to bill program clients for services that are incidental to covered services, including but not limited to, copying medical records and completing school and camp forms and other forms relating to clients' participation in sports and other activities. The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any cost sharing, as defined in section 17b-290(6) of the Connecticut General, and as permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being managed-care eligible, or a billed amount exceeding the program allowed amount. The provider may charge an eligible Connecticut Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services that are not covered under the Connecticut Medical Assistance Program, only when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them.

The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for the Connecticut Medical Assistance Program to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Connecticut Medical Assistance Program benefits.
17. To timely submit all financial information required under federal and state law.
18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.
19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.
20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.
21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information, including, but not limited to, records and information regarding payments claimed by the Provider for furnishing goods and services, will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations.
22. To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS

payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:

- a. medical records;
  - b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;
  - c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;
  - d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;
  - e. financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and
  - f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.
23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services, which represent an excess over the appropriate payment, or any payment owed to DSS because of a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.
24. To pay any applicable application fee, as required under federal law.

#### **Audits and Recoupment**

25. That in addition to the above provisions regarding billing and payment, Provider agrees that:
- a. amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;
  - b. whenever DSS makes a determination, which results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;
  - c. in a recoupment situation, DSS may determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:
    - (1) the amount of the indebtedness;
    - (2) the objective of completion of total recoupment of past overpayments as soon as possible;
    - (3) the cash flow of the Provider; and
    - (4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment;
  - d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;
  - e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this

subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and

- f. DSS's decision to exercise, or decision not to exercise, its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

### **Fraud and Abuse; Penalties**

26. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.
27. To comply with state and federal law, including, but not limited to, sections 1128, 1128A, 1128B, and 1909 of the Social Security Act (hereinafter the "Act") (42 U.S.C. §§ 1320a-7, 1320a-7a, 1320a-7b, 1396h) and Connecticut General Statutes sections 17b-301a to 17b-301p, inclusive, which provide state and federal penalties for violations connected with the Connecticut Medical Assistance Program.

Provider acknowledges and understands that the prohibitions set forth in state and federal law include, but are not limited to, the following:

- a. false statements, claims, misrepresentation, concealment, failure to disclose and conversion of benefits;
  - b. any giving or seeking of kickbacks, rebates, or similar remuneration;
  - c. charging or receiving reimbursement in excess of that provided by the State; and
  - d. false statements or misrepresentation in order to qualify as a provider.
28. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is terminated on or after January 1, 2011 under Title XVIII of the Act (Medicare) or any other state's Title XIX (Medicaid ) program or Title XXI (CHIP); is convicted of a criminal offense related to that person's involvement with Medicare, Medicaid or Title XXI programs in the last ten years; or if the Provider fails to submit timely and accurate information and cooperate with any screening methods required by law.
29. That suspension may result if the Provider is sanctioned by DSS for having engaged in fraudulent or abusive program practices or conduct, as set forth in state or federal law.
30. That, in accordance with federal law, DSS must temporarily suspend all Medicaid payments to a Provider after it determines there is a credible allegation of fraud for which an investigation is pending, unless DSS has good cause to not suspend payments or to suspend only in part.
31. To comply with the provisions of section 1902(a)(68) of the Act ( 42 U.S.C. § 1396a(a)(68)) and sections 17b-262-770 to 17b-262-773, inclusive, of the Regulations of Connecticut State Agencies, as they may be amended from time to time.

### **Nondiscrimination**

32. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, sexual orientation, mental retardation, mental or physical disability, including, but not limited to, blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

Provider further agrees to comply with:

- a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;
  - b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the "Rehabilitation Act") as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States
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shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

- c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, *et seq.*, as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and
- d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

### **Termination**

33. That this Agreement may be voluntarily terminated as follows:
  - a. by DSS or its fiscal agent upon 30 days written notice;
  - b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or
  - c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

### **Disclosure Requirements**

34. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 to 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:
  - a. the name, address, social security number and date of birth of any provider or any individual or managing employee (or tax identification number in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more;
  - b. whether any such person is related to another as spouse parent, child, or sibling;
  - c. the name of any other disclosing entity in which such a person also has an ownership or control interest;
  - d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000.00 during the 12-month period ending on the date of the request;
  - e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request;
  - f. the name of any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or other Connecticut Medical Assistance Programs since the inception of these programs; and
  - g. any other information requested in the Provider Enrollment application.

Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey, as applicable, and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this Agreement in accordance with 42 C.F.R. Part 455.

35. That the following penalties, as set forth in 42 C.F.R. §§455.104 to 455.106, inclusive, are applicable to Providers failing to make that section's required disclosures:
  - a. DSS will not approve an Agreement and must terminate an existing Agreement if the Provider fails to disclose ownership or control information;
  - b. DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or interest control, or who is an agent or a managing employee of the provider, has been convicted of a

criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program;

- c. DSS may refuse to enter into or terminate an Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

**Miscellaneous**

- 36. That the Agreement, upon execution, supersedes and replaces any Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.
- 37. The Provider acknowledges that there is no right to renew this Agreement.
- 38. The Provider will examine publicly available data, including but not limited to the U.S. Department of Health and Human Services Office of Inspector General (hereinafter "OIG"), or any successor agency's, List of Excluded Individuals/Entities Report and the OIG Web site, to determine whether any potential or current employees, contractors or suppliers have been suspended or excluded or terminated from any healthcare program and shall comply with, and give effect to, any such suspension, exclusion, or termination or accordance with the requirements of state and federal law. The Provider shall search the HHS-OIG Web site on a monthly basis, or at such intervals as specified by the OIG or DSS, to capture sanctions that have occurred since the Provider's last search. The Provider shall also routinely search the Administrative Actions List on the DSS website. The Provider shall immediately report to the OIG and to DSS any sanction information discovered in its search and report what action has been taken to ensure compliance with state and federal law. The Provider shall be subject to civil monetary penalties if it employs or enters into contracts with excluded individuals or entities.
- 39. If the provider uses electronic signatures, the provider certifies that the provider's policies meet the DSS requirements for acceptance, issuance, and use of electronic signatures.

The effective date of this Agreement and the period of time during which this Agreement shall be in effect, unless terminated by either party prior to the stated ending date, shall be written on the letter DSS sends to the Provider, through its Fiscal Agent Contractor, approving the Provider for participation in the Connecticut Medical Assistance Program. This approval letter shall be incorporated into and made part of this Agreement. If the Provider fails to complete an application for re-enrollment by the time the current Agreement has expired, DSS may stop making payments to the Provider, although DSS will retroactively make payments for services provided under the Connecticut Medical Assistance Program for up to six months from the date the re-enrollment was due.

**THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.**

**THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.**

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Provider Entity Name (doing business as)

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Name of Provider or Authorized Representative (type/print name)

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Signature of Provider or Authorized Representative

**Section L: Provider Agreement, continued - Addendum to Provider Agreement**



**STATE OF CONNECTICUT  
DEPARTMENT OF SOCIAL SERVICES  
Division of Health Services  
Addendum to Provider Enrollment Agreement  
for School-Based Child Health Providers**

(Name of Applicant)

(hereinafter the "Provider") wishes to participate in the Connecticut Medical Assistance Program as a School-Based Child Health ("SBCH") provider. The Connecticut Medical Assistance Program, including Medicaid, is administered by the State of Connecticut Department of Social Services ("DSS"). Except as otherwise specifically provided in this Addendum to Provider Enrollment Agreement (the "Addendum"), all provisions of the Provider Enrollment Agreement (the "Agreement") remain in full force and effect. This Addendum is incorporated by reference into the Agreement as if fully set forth therein and DSS may enforce this Addendum pursuant to all applicable authority, including, but not limited to, all authority specified in the Agreement. In addition to all representations and agreements made in the Agreement, the Provider also represents and agrees as follows:

1. To pay for the state share of Medicaid expenditures using only non-federal funds. The Provider agrees not to claim its SBCH services Medicaid expenditures for any federal matching funds. The Provider acknowledges that federal financial participation for SBCH services is paid to the State's General Fund and that DSS separately pays the Provider for SBCH services in accordance with section 10-76d of the Connecticut General Statutes and all other applicable statutes and regulations.
2. To use the Department of Administrative Services ("DAS") as the billing agent for SBCH services, unless otherwise instructed by DSS. The Provider shall submit claims on forms and in a manner specified by DSS or DAS.
3. To obtain and maintain parental consent for each client to bill Medicaid and send all required written notifications to each client's parents in accordance with 34 C.F.R. § 300.154(d).
4. To obtain written agreements from all of the Provider's subcontractors of SBCH services not to bill Medicaid directly for such services. The Provider agrees to return any funds that the subcontractor improperly received from Medicaid.
5. To develop an Individualized Education Program (an "IEP") for each client receiving SBCH services in accordance with state and federal statutes, regulations and policies, including, but not limited to, the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1414 and 34 C.F.R. Part 300, Subpart D; section 10-76d of the Connecticut General Statutes; and sections 10-76d-1 to 10-76d-19, inclusive, of the Regulations of Connecticut State Agencies.
6. To provide Medicaid covered SBCH services in accordance with each client's IEP and in compliance with applicable federal and state statutes, regulations and policies.
7. To provide DSS or its designee with all required information on a quarterly basis or more frequently as specified by DSS, including: lists of staff involved in SBCH services, billing and administration; IEP and other student statistics; SBCH cost reports; and any information or documents necessary for DSS or its designee to review the cost reports. The Provider shall maintain an ongoing list of all individual staff and subcontractors involved in providing SBCH services. In addition, the Provider shall also maintain license and certification documents for such staff and subcontractors.
8. To participate in periodic billing time studies as required by DSS and to provide all information and documents necessary for DSS to complete such time studies.

9. To maintain confidentiality of all Medicaid eligibility information in any format in accordance with applicable federal and state statutes and regulations. The Provider shall share such information only to the minimum extent necessary to perform, administer or bill for SBCH services.
10. To maintain the confidentiality of clients' health, treatment and educational records in accordance with all applicable requirements, including, but not limited to, the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g and 34 C.F.R. Part 99; IDEA, 20 U.S.C. § 1417(c) and 34 C.F.R. Part 300, Subpart F; and section 10-76d-18 of the Regulations of Connecticut State Agencies. Notwithstanding Paragraph 8 of the Agreement, the Provider is subject to the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d to 1320d-8, inclusive, and corresponding regulations ("HIPAA") only to the extent required by HIPAA.

**THE UNDERSIGNED, HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS ADDENDUM TO PROVIDER ENROLLMENT AGREEMENT, AND HAVING READ THIS ADDENDUM AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.**

**THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.**

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Provider Entity Name (doing business as)

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Name of Provider or Authorized Representative (type/print name)

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Signature of Provider or Authorized Representative