



STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

Applied Behavioral Analyst

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment. This site includes, but is not limited to enrollment applications for hospitals, hospice, laboratories, and groups.

Tennessee TennCare/Medicaid Providers must have completed applications forms on file before claims can be processed for payment. Please complete all documents and return to

**Department of Finance and Administration
Bureau of TennCare
Provider Registration Unit
310 Great Circle Road
Nashville, TN 37243**

All incomplete applications and requested documents not included will be returned to the pay-to address on your application. Original signature is required for all documents.

Tennessee Providers may obtain a copy of their licensure verification from the website of the State of Tennessee, Department of health listed bellow

<http://health.state.tn.us/Licensure/default.aspx>

Note: Out-of-State Providers must return a claim form with an attached Medicare Remittance for dually-eligible Medicare/Medicaid recipients, or a claim form only if billing for a TennCare recipient.

Completed Applications will be assign a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Manage Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment please contact:
1-800-852-2683.



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310 Great Circle Road
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CHECKLIST
Applied Behavioral Analyst

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following

Note: Please complete all forms in black ink only.

- Medicaid Provider Number** _____
- NPI Number** _____
- NPI Collection Form** _____
- No. 1 Sole Proprietor Application** _____
- Disclosure For Provider Person (required)** _____
- Substitute W-9 Form** _____
- Copy of License** _____
- Copy of License Renewal** _____
- OR**
- Copy of Certification** _____
- Copy of DEA Certification** _____
- Copy of CLIA Certification** _____
- Copy of Renewal** _____
- Copy of Verification of Credentialing from the BHO** _____

Applied Behavioral Analyst
NO 1 SOLE PROPRIETOR
APPLICATION



Provider Registration
310 Great Circle Road
Nashville, TN 37243

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

www.tn.gov/tenncare/pro-forms2.html

(Check all that apply) <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reactivation <input type="checkbox"/> Revalidation	<input type="checkbox"/> Adding Practice/Satellite Location <input type="checkbox"/> Name Change <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Tax ID Change
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Physician / Legal Business Name: _____
D/B/A: _____
Practice Location: (No P.O. Box #) _____
City: _____ State: _____ Zip Code + 4: _____
Telephone: _____ Fax: _____ County: _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

Legal Business Name as reported to the IRS: _____
D/B/A: _____
(Pay-To Address)
Street Address or P.O. Box: _____
City: _____ State: _____ Zip Code + 4: _____
Telephone No.: _____ Fax No.: _____
Federal Tax No. (IRS No.): _____ SSN No.: _____

NPI: _____ Taxonomy: _____

Applying For: Part A _____ Part B _____ Medical Specialty: _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

Federal Medicare No.: _____ State Medicaid No.: _____

Submit copies of professional and/or business licenses, accreditations, certifications, and registrations specifically required to operate as a health care provider.

License No: _____ Date of Issuance: _____ Expiration Date: _____

DEA No.: _____ Date of Issuance: _____ Expiration Date: _____

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Signature: _____ Date: _____

(Original Signature of Administrator, Agent, or Owner)

Printed Name: _____ Title: _____



STATE OF TENNESSEE
 THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
PROVIDER PARTICIPATION AGREEMENT
 MEDICAID/TENNCARE TITLE XIX PROGRAM

This statement includes the minimum standards to which the applicant must adhere to be enrolled in the Tennessee Medicaid health care program. Read these statements carefully.

By signing the Provider Participation Agreement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or revoked from the program if any conditions are violated. The Provider Participation Agreement must contain an original signature.

- 1) I have read the contents of the application and information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicaid or other federal health care contractor of this fact immediately;
- 2) Agree to accept the Medicaid payment as payment in full;
- 3) To maintain in Tennessee or in the State in which I practice, medical licenses and/or certifications as required;
- 4) Currently not under a Federal Drug Enforcement Agency (DEA) restriction of prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
- 5) Agree to maintain and provide access to Medicaid and/or its agency all Medicaid recipient medical records for five (5) years from the date of service or upon written authorization from Medicaid following an audit, whichever is shorter;
- 6) Provide medical assistance at or above recognized standards of practice; and
- 7) Comply with all contractual terms and Medicaid policies as outlined in Federal and State rules and regulations and Medicaid provider manuals and bulletins.
- 8) That failure to comply with any of the above provisions may subject a provider to actions described in Rule 1200-13-1.21.

Debarment and Suspension.

To the best of its knowledge and belief, the Contractor certifies by its signature to this Contract that the Contractor and its principals:

- A. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or State department or Contractor;
- B. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
- C. are not presently indicted for or otherwise criminally or civilly charged by a government entity (federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
- D. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, State, or Local) terminated for cause or default.

<u>Applicant name (printed)</u>	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc
Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc)				Date	
<i>FOR GROUPS AND ORGANIZATIONS:</i>					
<u>Authorized Representative Name</u> (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc
<u>Title/Position</u>	<u>Group Name</u>			<u>Medicare Identification Number</u>	
Applicant Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc)				Date	

SUBSTITUTE W-9 FORM
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

2. Circle the most appropriate category below: (please circle only one)

- 1) Individual (not an actual business)
 - 2) Joint account (two or more individuals)
 - 3) Custodian account of a minor
 - 4) a. Revocable savings trust (grantor is also trustee)
b. So-called trust account that is not a legal or valid trust under state law
 - 5) Sole proprietorship (using a social security number for the taxpayer ID)
 - 6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
 - 7) A valid trust, estate, or pension trust
 - 8) Corporation
 - 9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
 - 10) Partnership
 - 11) A broker or registered nominee
 - 12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
 - 13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)
-

3. Fill in your taxpayer identification number below: (please complete only one)

- 1) If you circled number 1-5 above, fill in your Social Security Number

__ - __ - __ - __ - __ - __

- 2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

__ - __ - __ - __ - __ - __

Sign and date the form:

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

**National Provider Identifier (NPI) Collection Form
(Individual/ Solo Practices)**

Any form not containing all required fields will be rejected.

**Section 1 – Provider General Information
(Please make additional copies if required)**

Provider Last Name	First Name	Middle	Title
Existing Medicaid ID's	SSN		EIN Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 2 – NPI Information

NPI Number _____
Taxonomy Codes

Section 3 – Primary Practice Location (As Entered on NPDES)

Address _____		

City _____	State _____	ZIP _____
_____	_____	_____
Phone Number _____	Fax Number _____	Provider e-mail Address _____

Section 4 – Contact Information

Name of Individual Completing Form _____		

Phone Number _____	Fax Number _____	Contact e-mail Address _____

Signature _____	Title _____
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NPI Collection Form Surety Statement:
“I certify that the information provided on this application is complete and correct to the best of my knowledge.”

Instructions Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243 - 1700
Fax	(615) 248-4386 or (866) 456-8059
Field	Instruction
Section 1 – Provider General Information	
Provider Last Name	(Required) Enter the provider's last name.
First Name	(Required) Enter the provider's first name.
Middle	(Optional) Enter the provider's middle name.
Title	(Required) Enter the provider's title.
Existing Medicaid ID's	(Required) Enter all currently assigned Medicaid provider numbers.
SSN	(Required) for an individual provider. Enter the Social Security Number.
EIN Number	(Required) Enter the Employer Identification Number (could be SSN).
Section 2 – NPI Information	
National Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPPES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPPES.
ZIP	(Required) Enter the primary practice location ZIP of the provider as entered in the NPPES. If known, include the ZIP +4.
Phone Number with area code	(Required) Enter the primary practice location phone number of the provider as entered in the NPPES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPPES.
Provider e-mail Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES.
Section 4 – Contact Information	
Name of Individual Completing Form	(Required) Enter the name of the individual completing this form.
Phone Number with area code	(Required) Enter the phone number of the individual completing this form.
Fax Number with area code	(Optional) Enter the fax number of the individual completing this form.
Contact e-mail Address	(Optional) Enter the e-mail address of the individual completing this form.
Signature and Title	Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form.

DISCLOSURE FORM FOR A PROVIDER PERSON

Directions: Use this form if you are trying to get a TennCare/Medicaid provider ID number for a **Provider Person**. If the addition of the **Provider Person** will change the **Ownership** or **Control** structure of the **Provider Entity** that the **Provider Person** is joining (i.e. the new **Provider Person** will also be an owner or high ranking employee of the **Provider Entity**, then you must also fill out a new Disclosure form for the **Provider Entity** to reflect the new **Ownership** or **Control** arrangements.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return this form to the address on the application packet. Go to the TennCare Program Integrity website for a list of contact information for each MCO. Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond N/A for that question. **NO QUESTIONS SHOULD BE LEFT BLANK**. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Social Security Numbers (SSN) must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing (SSN).

Name of person completing form	Phone number of person completing form

I. Identifying Information

Provider Person name	SSN	DOB	NPI number (if you have one, if not indicate if applied for)	TennCare/Medicaid Id number (if you have one, if not indicate if applied for”)

Provider Person Home Address	City	State	Zip

Provider Entity name (Provider Entity is who the Provider person works for. If you are a sole proprietor you would list yourself as the Provider Entity also.)	Provider Entity DBA (If different from provider Entity Name)	Provider Entity Address (If you have more than one practice location list all locations)

Provider Entity T.I.N.	Provider N.P.I. (if the Entity has one, if not indicate if applied for)	Provider TennCare/Medicaid I.D. number (if the Entity has one, if not indicate if applied for)

II. Criminal Offense Attestation

A) Have you ever been **Convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **“Convicted”** means been found guilty by a jury or judge, or pled guilty, nolo contendere, best interest plea or pre trial diversion or suspended sentence. Yes No

If ‘Yes’ is checked, provide the following information:

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

B) Have you ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means you are not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes No

If ‘Yes’ is checked, provide the following information:

When you were debarred	Length of Debarment	Reason for Debarment

C) Have you ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past? “Excluded” means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

Yes No If “Yes”, please supply the following information:

Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

D) Have you ever been **Terminated** from a State’s Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a State’s Medicaid or SCHIP programs for a cause related to fraud or abuse.

Yes No If “Yes”, please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

Yes No If “Yes”, please supply the following information:

State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

|

III. Questions for a Sole Proprietor

a) If you are a Sole Proprietor, please give the following information for your **Managing Employees and Agents**. A **Managing Employee** is someone who makes day to day decisions on the running of your business such as an office manager or billing manager. An **Agent** is someone besides yourself who can legally act for your business.

Name of Managing Employee or Agent	SSN	DOB	Home Address	City	State	Zip

b) Has any person listed in 3a been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **“Convicted”** means been found guilty by a jury or judge, or pled guilty, nolo contendere, best interest plea or pre trial diversion or suspended sentence. Yes No . If yes, please provide the following information:

Name on Court records	SSN	Matter of the Offense	Date of the Conviction	Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general(OIG)

c) Has anyone on the list in 3a ever been **Debarred** from participation in Federal Government contracts? **“Debarred”** means someone is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes No

If ‘Yes’ is checked, provide the following information:

When the individual was debarred	Length of Debarment	Reason for Debarment

d) Has any person on the list in 3a ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past?

Yes No If “Yes”, please supply the following information:

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

e) Have anyone on the list in 3a ever been terminated from a State’s Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?

Yes No If “Yes”, please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

f) Has any person on the list in 3a ever had **Civil Monetary Penalties (CMPs)** assessed against them?

Yes No If “Yes”, please supply the following information:

Name Of Individual	State where practicing when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

IV. Signature

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of the Provider;

Name of Provider Person (Printed)	Signature of Provider Person	Date

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
ACH (AUTOMATED CLEARING HOUSE) CREDITS (NOT WIRE TRANSFERS)

NAME _____

Federal Identification Number or Social Security Number _____
(Under which you are doing business with the State)

I (We) hereby authorize the State of Tennessee, hereafter called the STATE, to initiate credit entries to my (our) *(select type of account)* _____ **CHECKING** or _____ **SAVINGS** account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

This authority is to remain in full force and effect until the STATE has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the STATE and DEPOSITORY a reasonable opportunity to act on it.

Do you currently receive payments from the STATE through ACH? ____ *(Yes or No)*. If yes, do you intend for this account information to replace other existing account information currently used by the STATE? ____ *(yes or no)*. If yes, please specify the account that should be changed: ABA No. _____ Account No. _____.

Is this authorization only for certain types of payments? ____ *(Yes or No)*, If yes, please indicate types:

Many banking institutions use different numbers for ACH. Please call your bank for verification of ACH transit and account number.

Bank official contacted: _____ Phone No. _____

DEPOSITORY/BANK NAME _____ BRANCH _____

CITY _____ STATE _____

ACH TRANSIT/ABA NO. _____ ACCOUNT NO. _____

NAME(S) _____
Please print names of authorized account signatory)

DATE _____ SIGNED X _____ SIGNED X _____

PLEASE ATTACH A VOIDED CHECK (OR FOR SAVINGS ACCOUNTS, A DEPOSIT SLIP):

PLEASE INDICATE ADDRESS TO WHICH YOU WOULD LIKE YOUR REMITTANCE ADVICES ROUTED WHEN PAYMENTS ARE PROCESSED:

Contact name: _____

Telephone no: _____

FOR STATE USE ONLY
Contact Agency: _____
Contact Person: _____
Telephone No.: _____