



**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

ICF/Level I Nursing Home Providers

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.

All documents must have original signatures

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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CHECKLIST

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

ICF/ Level I Nursing Home Provider

Medicaid Provider Number _____

NPI Number _____

NPI Collection Form (Required) _____

Copy of License (Required) _____

Disclosure of Ownership (Required) _____

No. 3 Application ICF Level I

 Recertification _____

 New _____

 Change of ownership _____

Substitute W-9 Form _____

Participating Agreement for Level I Signed by Provider: _____
(Contract)

For Office Use Only

Contract: Signed by Commissioner/Assistant Commissioner _____
(date)

File Completed Yes _____ No _____
(date)

(INITIALS)

NOTE: PLEASE RETURN THIS FORM WITH THE ENROLLMENT PACKET AND PROVIDE AN EMAIL ADDRESS TO RECEIVE A COPY OF THE COMPLETED CONTRACTS.

EMAIL COPY OF EXECUTED CONTRACT TO: _____

ICF/Level I Nursing Home
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/longtermcare2.html

(Check all that apply) <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Recertification	<input type="checkbox"/> Reactivation <input type="checkbox"/> Revalidation <input type="checkbox"/> Name Change <input type="checkbox"/> Tax ID # Change
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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 Name: _____
(Pay-To Address)
Street Address or P.O. Box: _____
City: _____ State: _____ Zip Code + 4: _____
Telephone No.: _____ Fax No.: _____

Federal Tax No. (IRS No.): _____ NPI No.: _____ Taxonomy: _____

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

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

Medical supplies and durable medical equipment only — briefly describe the types of items and equipment you propose to supply 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: _____

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 Group Practices/Facilities

Any form not containing all required fields will be rejected.

Section 1 – Provider General Information

Business Name _____
Doing Business As (Name) _____

Medicaid ID
EIN
NPI
Taxonomy Codes _____

Section 2 – NPI Information

(Please Complete this Section for each Individual Provider that is associated with your Group. Please Make additional copies if required)

Provider Name	Medicaid ID	NPI	SSN	Taxonomy	Taxonomy

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

Address _____

City
State
ZIP

Phone Number
Fax Number
Provider Email Address

Section 4 – Contact Information

Name of Individual Completing Form _____

Phone Number
Fax Number
Contact Email Address

Signature _____ **Title** _____

**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

Group Practices/Facilities

Send the completed NPI Collection Form via one of the following means:

Mail	Provider Enrollment Attn: NPI Collection 310 Great Circle Rd. Nashville, TN 37243
Fax	(615) 248-4386 or (866) 456-0859
Field	Instruction
Section 1 – Provider General Information and NPI Information	
Provider Business Name	(Required) Enter the provider's name (Facilities, Agencies, Groups, Hospitals, etc.).
D/B/A Name	(Required If Applicable).
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
EIN	(Required for a business entity) Enter the Employer Identification Number.
National Provider Identification Number	(Required) Enter the National Plan and Provider Enumeration System (NPDES) assigned NPI.
Section 2 – Group Member - NPI Information	
Provider Name	(Required) Enter the individual provider name linked to this group number.
Medicaid ID No.	(Required) Enter the 7-digit Medicaid provider number.
NPI Individual Provider Identifier	(Required) Enter the National Plan and Provider Enumeration System (NPDES) assigned NPI.
Social Security Number	(Required) Enter the Individual Provider SSN.
Taxonomy Codes	(Required) Enter the Taxonomy codes associated with the assigned NPI.
Section 3 – Primary Practice Location	
Address	(Required) Enter the primary practice location address of the provider as entered in the NPDES.
City	(Required) Enter the primary practice location City of the provider as entered in the NPDES.
State	(Required) Enter the primary practice location State of the provider as entered in the NPDES.
ZIP	(Required) Enter the primary practice location zip of the provider as entered in the NPDES. 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 NPDES.
Fax Number with area code	(Optional) Enter the primary practice location fax number of the provider as entered in the NPDES.
Provider Email Address	(Optional) Enter the primary practice location e-mail address of the provider as entered in the NPDES.
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 Email Address	(Optional) Enter the email address of the individual completing this form.
Signature/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.

BUREAU OF TENNCARE
 Provider Registration Unit
 310 Great Circle Road
 NASHVILLE, TENNESSEE 37243

DISCLOSURE FORM FOR PROVIDER ENTITIES

Directions: Use this form if you are trying to get a new TennCare/Medicaid ID number for a **Provider Entity**, or if you are re-credentialing or re-contracting a **Provider Entity**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **Provider Entity** is a business entity. i.e. a partnership or corporation, that provides TennCare covered services to TennCare enrollees.

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 the original to the Bureau of TennCare at the address above and mail copies of the original to any Managed Care Organization (MCO) you participate with. 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.** The SSN must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing Social Security Numbers (SSN).

I. Identifying Information

Name of person Completing form	Phone number of person completing form

Provider Entity Name	Provider DBA Name (if different from Provider Entity name)	Provider Federal Tax Id number

Provider NPI number (If you have one, if not indicate if applied for.)	Provider TennCare/Medicaid ID number (If you have one, if not indicate if applied for.)	Provider telephone Number

Provider Address- Must include at least one street address. (attach a separate sheet if needed).List all Practice locations	City	State	Zip

II. OWNER OR CONTROL INFORMATION

Directions: An “Owner” is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity. This 5% may be Direct ownership or Indirect ownership i.e, an individual might own 50% of a company that owns the actual Provider Entity meaning their indirect ownership is 50%. In addition to ownership of stock, an Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

A person with “Control” is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the Provider Entity is a non-profit entity, respond N/A in the column for % of ownership.

A “Managing Employee” is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An “Agent” is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Please provide the following information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet if needed.

Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**?

Yes No . If “yes”, please provide the following information about the other **Provider Entity** the person on the **Master List** has an interest in.

Name of other Provider entity	Address	City	State	Zip	Tax I.D.

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Tricare or the Title XX services program since the inception of those programs? Yes No . If yes, please provide the information requested below:

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? “**Debarred**” means an individual 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 you were debarred	Length of Debarment	Reason for Debarment

5) Has any person or entity on the **Master List** 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:

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

6) Has any person or entity on the **Master List** ever been **Terminated** from a State’s Medicaid or SCHIP 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

7) Has any person or entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them? 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:

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

8) Did anyone on the **Master List** obtain their **Ownership** interest 1)as a result of a transfer of ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare Program.: And 2) where the original **Owner** is or was a member of the **current Owner’s Immediate Family** or Member

								Title

9c) Is anybody in the list in 8b list related to any person in the **Master List** above?

Yes No If yes, please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. Business transactions

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* \$25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.8a. in which you have an ownership interest. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** business functions, i.e., billing agent, or to provide medical services, i.e., a medical lab.

Name	Address	City	State	Zip

2) Does the **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Yes No . If yes, supply the following information about the **Supplier**:

Name	Address	City	State	Zip	NPI	TI N

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 an individual who can legally bind this **Provider Entity**:

Name of Person (Printed)	Signature of Person	Title	Date



MEDICAL ASSISTANCE PARTICIPATION AGREEMENT
(MEDICAID/TENNCARE TITLE XIX PROGRAM)

Between
THE STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
Bureau of TennCare
And

PROVIDER NAME

FOR
LEVEL I NURSING SERVICES

This Provider Agreement, hereinafter referred to as the “Contract” and/or “Agreement”, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the “Department” or “TennCare”, and _____, hereinafter referred to as the “Contractor” or the “Facility”, is for the provision of Long Term Care Services in a Nursing Facility (NF) as further defined below:

THE TERMS, OBLIGATIONS AND CONDITIONS

I. The Facility Agrees:

A. Patient Care:

1. To provide Level I care to eligible individuals in accordance with all applicable State and Federal laws, rules, and regulations.
2. To maintain all necessary records on each recipient at the Facility in accordance with State and Federal regulations. These records and pertinent staff are to be made available to the Department and its authorized representatives on request.
3. To participate with the Department’s Independent Professional Review Team in the evaluation of the necessity, adequacy, quality and appropriateness of care and of each recipient’s physical and mental condition in order to determine the kinds and amounts of care needed.
4. To acknowledge and take the appropriate corrective action indicated by the Independent Professional Review Team’s report within the time limits specified by the Department.

5. To comply with the State and Federal Regulations which govern the admission, transfer or discharge policies for recipients.
6. To provide the Department or its authorized representative with a completed pre-admission evaluation for each recipient as required by State and Federal Regulations. If application is made while the patient is in the Facility the pre-admission evaluation must be completed prior to requesting payment for services.
7. To provide the Department with certification and recertification that the level of care is necessary and appropriate. (This requirement is satisfied by the dated signature of the attending physician on the appropriate form.)
8. To ensure that a physician sees each recipient at an interval of no less than once every sixty (60) days unless an alternative visitation schedule is approved by the Department.
9. To ensure that all medications are reviewed monthly by a registered nurse and at least quarterly by a physician.
10. To prearrange for physician services in the event of an emergency or the non-availability of the attending physician.
11. To have on file and make available to the Department's authorized personnel, on request, copies of the transfer forms used when transferring a resident from one Facility to another (i.e., nursing homes, skilled facilities, hospitals, etc.) and to provide referral information to other facilities.
12. To safeguard all required records and information from loss or unauthorized use, and to maintain them for a minimum of ten (10) years following recipient's discharge or death.
13. To provide or arrange for social services, as needed by the recipient, which are designed to promote the preservation of the resident's physical and mental health.
14. To have on file and make available to the Department's authorized representative, on request, a social service plan of care in each resident's record. This plan will be evaluated periodically by the facility and altered appropriately.
15. In the event the facility does not employ a licensed pharmacist, to have a formal agreement with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal and record keeping of drugs and biologicals.
16. To provide an activities program designed to encourage restoration to self-care and maintenance of normal activity.

17. To have on file and make available to the Department's authorized representative, on request, a plan for individual and group activity developed for each resident in accordance with his or her needs, interests and capabilities. This plan must be reviewed with the resident's participation to the extent practicable, as often as needed but no less than quarterly.
18. To provide or make arrangements for each resident, the needed specialized and supportive rehabilitative services and restorative nursing care.
19. To accept periodic compliance reviews and to comply with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. The Facility further gives assurance that, as a condition of receiving payment from TennCare for care and services for which Federal funds are used, no distinction on grounds of race, color, national origin or handicap is made in accepting individuals for care or in the treatment or services provided. It is further agreed that subject to appropriate legal and professional limitations, records of admission (or intake), discharge, and other operations controlling the conditions of care or service provided will be made available to the Commissioner of the Department or his designated representative for review at any time that the Department or the Tennessee Department of Health receives an official complaint of discrimination made by or on behalf of any applicant, recipient, or other beneficiary of the nursing home program.
20. To have on file and make available on request of the authorized representatives of the Department and the Comptroller of the Treasury, a system designed and utilized to ensure the integrity of the recipient's personal financial resources. This system will be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable Code of Federal Regulations.
21. To ensure compliance of the Facility with all Federal and State statutes, regulations, and guidelines regarding reimbursement and patient care by making timely corrections of any deficiencies made known to the Facility.
22. To have in force an approved utilization review plan in accordance with State and Federal Regulations. The plan must be written and must provide for a review of the necessity for continued stay at least every six months or more frequently if indicated at the time of assessment.
23. To promptly notify the Department of Human Services office in the county in which the facility is located when a recipient is admitted, or

when there is a known change in circumstances and give notification prior to the recipient's discharge.

24. To mail NF records to the Department upon request of the Department.

B. Reimbursement:

1. To accept the amount of vendor payment from the Department and patient liability as payment in full for all covered services.
2. To make no charge for covered services provided to a recipient of Medicaid/TennCare which is in excess of charges made to other patients being provided the same type of services in the Facility.
3. To accept the reimbursable cost rate established by the Comptroller of the Treasury as the maximum rate to be allowed for the Facility's covered services. (The Comptroller of the Treasury will establish per diem reimbursement rates for the institutions or distinct parts thereof rendering intermediate care. The Comptroller of the Treasury will advise both the provider and the Department of any new rate or rate change).
4. To submit to the Comptroller of the Treasury a cost report on forms designated by the Comptroller at the Facility's fiscal year end. This report will be due three months from the end of the designated fiscal period. Such cost report must be completed in accordance with the principles of cost reimbursement as set out by the Department or the Comptroller of the Treasury. In the event that the Facility does not file the required information by the due date, unless an extension in writing has been granted, the institution shall be entitled to a maximum reimbursable per diem rate of not more than four dollars (\$ 4.00) in accordance with state law.
5. To allow the Department, the Comptroller of the Treasury or their agents to audit the cost report and records of a Facility in order to verify the cost data or other information submitted by the provider and to investigate possible infractions of Intermediate Care regulations, and to maintain such records in accordance with any regulations promulgated by the Comptroller of the Treasury.
6. To have on file and make available to the Department's authorized personnel and to the Comptroller of the Treasury or its agent, all contracts for covered services provided by a provider other than the Facility itself.
7. To complete, in duplicate, itemized statements of extra charges for supplies or services extraneous to regular routine Level I care. The original itemized statement will be given to the recipient or other appropriate third party. The first copy will be kept on file by the Facility and be subject to State audit for a period of three years or until audited. The recipient-patient will not be charged for items included in the

determination of Reimbursable Per Diem Cost Per Patient, nor will the Facility charge for health services available to recipients under the Medicare or other Medicaid/TennCare Programs.

8. To execute a written financial contract with each recipient-patient or with his or her agreed-upon representative upon admission of the patient. The contract will set out the rate of regular patient charge, if less than the reimbursable cost. Also, it shall designate the patient's financial resources which will be forthcoming from all sources and applied toward meeting the cost of care. One copy of the financial contract will be maintained in the Facility's files.

C. Disclosure of Ownership And Related Information:

1. To keep any records necessary to disclose the extent of services the provider furnishes to recipients.
2. To furnish the Medicaid/TennCare agency, the Centers for Medicaid and Medicare Services (CMS), or the State Medicaid/TennCare fraud control unit on request any information contained in the records including information regarding payments claimed by the provider for furnishing services under the plan.
3. To disclose to the Department the identity of any person who has an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.
4. To disclose to the Department the name and address of each person with an ownership or control interest in the Facility, or is an agent or managing employee of the Facility.
5. To inform the Department of the name and address of each person with an ownership or control interest in the disclosing entity or in a subcontractor in which the disclosing entity has a direct or indirect ownership interest of five (5) percent or more.
6. To name any other disclosing entity in which a person(s) with an ownership or control interest in the disclosing entity also has an ownership or control interest. This applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person.
7. To keep copies of all requests and the responses to them in accordance with I . C. 6. above and to make them available to CMS or the Medicaid agency upon request and advise the Medicaid agency when there is no response to a request.
8. To submit within thirty-five (35) days of the date of request by the CMS or the Medicaid agency full and complete information about:

- (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000.00 during the twelve (12) month period ending on the date of the request.
 - (2) Any significant business transactions between the provider and any wholly owned supplier, or between the facility and any subcontractor, during the five (5) year period ending on the date of the request.
9. To disclose to the Department the identity of any person in accordance with I. C. 3. above that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid/TennCare or the Title XX services Program since the inception of those programs.

II The Department Agrees:

- A. To reimburse the Facility on a timely basis in the amount of vendor payment not to exceed the maximum Reimbursable Per Diem Rate established by the Comptroller of the Treasury.
- B. To provide such expertise and assistance to the Facility in reference to governmental regulations of the Intermediate Care Facility program as may be required by the Facility.

III The Department and Facility Mutually Agree:

- A. That the term "Administrator" appearing in the signature portion of the Contract is interpreted to mean the present Administrator of the Facility or his successor.
- B. That, in the event the U. S. Department of Health and Human Services terminates the Facility from the program, the Department will not be liable for the payments suspended by such action.
- C. This Agreement will automatically terminate no later than the 60th day following the end of the time period specified for the correction of non-waived deficiencies cited during the federal certification process, if such deficiencies have not been corrected, or substantial progress made in correcting these deficiencies. This process is subject to applicable State and Federal Regulations pertaining to appeals.
- D. That the Department may cancel this Agreement in accordance with State and Federal regulations when in its judgment the Facility has failed to abide by the terms and conditions of said Agreement. The Department may also immediately suspend payments for any future services under this Agreement. Within 30 days of such suspension, the Facility will have the right to request a fair hearing so that it may show cause why such payments should be reinstated.

- E. That as the Federal standards for participation are amended, modified, or changed, the Department shall immediately furnish the Facility a copy of any such changes, and the Facility shall accept such amendment, modification, or change by acknowledging such change within 30 days from receipt thereof; such signed acknowledgement by the Facility shall become a part of this Agreement, the same as if written into the Agreement, and the failure of the Facility to execute the acknowledgement and return it to the Department shall constitute an automatic revocation of this Agreement.
- F. That the effective date for vendor payments shall be the date that the Facility attains participating status as determined by the Department under Federal standards for participation and that such determination shall be made a part of this Agreement.
- G. That should the Office of the Comptroller, through audit of the Facility, discover that amounts have been overcharged and collected from the individual recipients; the Facility will place the overcharged amounts in escrow accounts, approved by the Department, for the recipients, should the Facility choose to contest these findings. Otherwise, the Facility will promptly reimburse the recipients.
- H. That should the Office of the Comptroller, through audit of the Facility, discover irregularities which in its opinion constitute overpayments to the Facility by the Department, the Department may withhold the amount of such overpayments from future payments to the Facility until an amount equal to that overpaid by the Department has been collected from payments otherwise due the Facility. The reimbursement of these overpayments, upon request by the Facility, may be made on an installment payment plan.
- I. The Facility, or the State, may cancel this Agreement by providing the other party with thirty (30) days written notice of such intent.

Confidentiality of Records.

Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the

State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Contractor to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

HIPAA Compliance.

Contractor warrants to the State that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract. Contractor warrants that it will cooperate with the State in the course of performance of the Contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Contractor will sign any documents that are reasonably necessary to keep the State and Contractor in compliance with HIPAA, including but not limited to business associate agreements.

Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU) Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records that relate to the delivery of items or services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special

circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

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.

Contract Beginning Date : _____

Contract Ending Date: _____

Automatic Cancellation Clause Date: _____

Subject to Provision III – C (See Page 6)

Name of NURSING FACILITY : _____

Address : _____

Provider Number : _____

NH License # _____

By : _____

Date

Name and Title

Tennessee Department of Finance and Administration, Title XI X Agency

By : _____

Commissioner

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:

_____ Telephone no: _____ Contact name: _____

FOR STATE USE ONLY

Contact Agency: _____
Contact Person: _____
Telephone No.: _____