



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

Instate and Out-Of-State Hospital 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.

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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CHECKLIST
Instate and Out-of-State Hospital Providers

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 (Required) _____

Medicare Approval Letter (Required) _____

State License (Required) _____

CLIA Certificate (If Applicable) _____

DEA Certificate (If Applicable) _____

Disclosure of Ownership (Required) _____

No. 3 Group Practice Application

New _____

Change of ownership _____

Revalidation _____

Substitute W-9 Form _____

Claim Form (Out-of-State Only) (Required) _____

Contract (Instate Only) (Required) Signed by Provider: _____

For Office Use Only

Contract: Signed by Commissioner/Assistant Commissioner

(date)

Executed Contract Returned to Provider

(date)

File Completed Yes _____ No _____

(date)

(INITIAL)

NOTE: THIS FORM MUST BE RETURNED WITH THE ENROLLMENT PACKET

If you would like your executed Contract to be e-mailed, please provide your e-mail address here: _____

HOSPITAL 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"/> Change of Ownership <input type="checkbox"/> Revalidation		<input type="checkbox"/> Reactivation <input type="checkbox"/> Adding Practice/Satellite Location <input type="checkbox"/> Name Change <input type="checkbox"/> Tax ID # Change	
Indicate Provider Type (Check One)			
<input type="checkbox"/> Acute	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Swing Bed	
<input type="checkbox"/> Critical Access	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Other	

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.): _____ 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.

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 this form to the address on the application packet. 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 Entity DBA Name (if different from Provider Entity name)	Provider Entity Federal Tax Id number

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

Provider Entity 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 Interest” 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. If the company is a non-profit please put N/A in % ownership column.

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 CHIP 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 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 CHIP 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 **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect 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 of** the current owner’s **Household**, at the time of the transfer of ownership? [**Immediate Family**] is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Member of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.]

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

Name of original Owner	SSN or TAX ID of original Owner	Place of Transfer	Date of Transfer

9a) List any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities’** management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

9b) For each **Subcontractor(s)** listed in 8a above please provide the following information for the individuals with an Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s)**. See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address (for individuals use Home address, for business entities that might have a Direct or Indirect Ownership or Control Interest use business street address, and P.O. Box address if any.)	City	ST	Zip	DOB	SSN for individuals or Tax ID for business entities	% of ownership	Title

9c) Is anybody in the list in 9b 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 **Direct or Indirect 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	TIN

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



STATE OF TENNESSEE
THE TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
MEDICAL ASSISTANCE PARTICIPATION AGREEMENT
(MEDICAID / TENNCARE TITLE XIX PROGRAM)
FOR
INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Name of Hospital : _____
Address : _____
Hospital License No. : _____ Medicaid Provider No.: _____

This agreement and working contract, entered into the _____ day of _____, _____, between the Tennessee Department of Finance and Administration, hereinafter referred to as "the Department" and

(Name of Hospital)

(City and State)

(Zip Code)

an institution for providing inpatient and outpatient hospital services and other supportive patient services for which it is currently licensed and certified, hereinafter referred as "the Facility".

I. The Facility Agrees :

- A. To participate in the Tennessee Medicaid/TennCare program by providing major medical and surgical and/or acute short term care in return for considerations received from the Department.
- B. To remain licensed under the laws of the State of Tennessee and fully meet other minimum standards for participation as follows :
 - 1. To remain fully certified for participation in Medicare;
 - 2. To meet all health and safety requirements or have a written plan of improvement that will meet all requirements for approval by the Health Care Facilities Licensing Division of the Department.
- C. To maintain accounting records that will enable the Facility to comply with "Principles of Reimbursement for Provider Costs HIM5 (revised 1-67) SSA.

- D. To comply with the policies and procedures prescribed or required by the Department in the administration of the Medical Assistance Program.
- E. To abide by all laws, regulations, policies and procedures applicable to services rendered under Medicaid/TennCare Title XIX Program.
- F. To render the same quality of service to Medicaid recipients as rendered to private patients.
- G. To maintain the Outpatient Department as an integral part of the FACILITY and as such licensed under the laws of Tennessee.
- H. To complete the necessary treatment and discharge recipients from the Facility in the minimum number of days consistent with good medical practices as determined by an active utilization review committee, or PSRO, when under binding review.
- I. To provide services to eligible Medicaid/TennCare recipients and comply with the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 which prohibit a participating provider or vendor of services from making a distinction on the basis of race, color, national origin or handicap.
- J. To render services to be paid under Medicaid/TennCare Title XIX Program, only to holders of valid recipient Identification (ID) Cards upon presentation and proper identification.
- K. To submit to the designated fiscal agent for reimbursement only those items of authorized hospital services that are actually provided to eligible recipients under the Medical Assistance Program (Title XIX).
- L. That payment made to the Facility by the Department or its agent under this program will be accepted as payment in full for the care of the patient and that no additional charge will be made to the patient, any member of his family, or responsible agent.
- M. To apply as a credit against the total reimbursable amount any hospitalization insurance or any other third party payment applicable to the period for which the state assumes responsibility, said period to be construed as beginning on the date of authorized admission of the individual patient.
- N. To accept the same method of reimbursement for Title XIX services that is used for reimbursement of Title XVIII, Medicare services.
- O. To have a desk review and audit after each fiscal year end, as may be required, with an appropriate adjustment. If there has been a payment in excess of "reasonable costs" during the audit period, the Facility agrees to refund the excess payment.

- P. To make pertinent medical information available to authorized representatives of the Department subject to appropriate legal, ethical and professional considerations.
- Q. To make available to the Department or its representative, the necessary fiscal records, including audit reports and work papers prepared by Part A Medicare fiscal intermediary auditors, for the Title XIX retroactive adjustments.
- R. To keep any records necessary to disclose the extent of services the provider furnishes to recipients.
- S. To make available on request of the Department, the Secretary of the State Medicaid/TennCare fraud control unit any information contained in the records including information regarding payments claimed by the provider for furnishing services under the plan.
- T. To disclose to the Department the identity of any person who has ownership or control interest in the Facility, or is an agent or managing employee of the Facility.
- U. To disclose to the Department 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.
- V. To inform the Department if any person(s) named, in compliance with I.U, above is related to another as a spouse, parent, child or sibling.
- W. To name any other disclosing entity in which a person(s) with an ownership or control interest in the disclosing facility 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.
- X. To keep copies of all requests and the responses to them in accordance with I. W. above, and to make them available to the Secretary or the Department on request, and to advise the Medicaid/TennCare agency when there is no response to a request.
- Y. To submit within thirty-five (35) days of the date of a request by the Secretary or the Department full and complete information about :
 - 1. The ownership or 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 the subcontractor during the five (5) year period ending on the date of the request.

- Z. To furnish updated information to the Secretary or the State Survey Agency or Medicaid/TennCare agency at intervals between recertification or contract renewals within thirty-five (35) days of a written request.
- A1. To disclose to the Department the identity of any person in accordance with I. T. 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 XIX services program since the inception of those programs.

II. The Department Agrees :

- A. To give the Facility reasonable notice of any impending change in its status as an Inpatient and Outpatient Hospital provider.
- B. To notify the Facility of any major changes in Title XIX Rules and Regulations, and to work with the Facility with the view toward providing the best medical care available within the limitations of the law and available money.

III. MEDICAID/TENNCARE and the FACILITY Agree :

- A. That payments to the Facility may be withheld, if necessary, because of irregularity from whatever cause, until such irregularity or difference can be adjusted.
- B. That proper adjustments in vendor payments will be made (as indicated to compensate for either overpayment or underpayment).
- C. That if any part of this agreement is found to be in conflict with any Federal or State law or regulation, having equal weight of law, or if any part is placed in conflict by amending of such law, this agreement is so amended.
- D. That Tennessee Code Annotated, Chapter 19, Section 14-1923, is made part of this agreement and quoted as follows :

"Any individual or corporate vendors or provider participating under the provisions of this chapter who holds an equity interest in any hospital, apothecary, nursing home, or other vendor or provider participating under the provisions of this chapter shall submit annually to the Department of Finance and Administration information disclosing their interest in these vendors and providers. Any such party who fails to file the information required by this section shall not be entitled to participate in the program."

- E. That the effective date for vendor payments will be the date the Facility attains participating status as determined by the Department and that such determination shall be made a part of this agreement.
- F. That by signing this agreement, the Facility and the Department accept all of the stipulations in the agreement and agree to each and every provision herein. The parties further agree that any failure on the part of either to comply

with any of the provisions set out above shall be considered a breach of this contract and that such contract shall be subject to immediate cancellation.

G. That the Department or Facility may cancel this agreement by providing the other party with written notice.

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 the 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.

TBI MFCU Access to Contractor and Provider Records Program Integrity Access to Contractor, Provider, and Enrollee Records.

Pursuant to Executive Order 47 and 42 C.F.R. § 1007, the Tennessee Bureau of Investigation Medicaid Fraud Control Unit (TBI MFCU) is the state agency responsible for the investigation of provider fraud, abuse, and neglect in the State Medicaid program (TennCare).

Program Integrity assists TBI MFCU with provider cases and has the primary responsibility to investigate TennCare enrollee fraud and abuse.

The Contractor shall immediately report to the TBI MFCU any known or suspected fraud, abuse, waste and/or neglect, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies 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 the TBI MFCU, and must cooperate fully in any investigation by the TBI MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers, whether participating or non-participating providers, shall, upon request, make available to the TBI MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which TennCare monies are expended. In addition, the TBI MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, whether participating or non-participating, during normal business hours, except under special circumstances when after hour admission shall be allowed. The TBI MFCU shall determine any and all special circumstances.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, TBI MFCU is a health oversight agency. See 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. In its capacity as a health oversight agency, TBI MFCU does not need authorization in order to obtain enrollee protected health information (PHI). PHI is defined at 45 C.F.R. § 164.501. Because MFCU will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to those disclosures to TBI MFCU that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d) and 65 F.R. §§ 82462 and 82673.

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.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to Program Integrity. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. The Contractor and its health care providers, whether participating or non-participating providers, shall, upon request, make available any and all supporting documentation/records relating to delivery of items or services for which TennCare monies are expended. Shall the need arise, Program Integrity 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.

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.

This contract shall take effect on the date of the on site health and safety survey if all federal requirements are met, if all requirements are met, or the date the provider submits an acceptable plan of correction or waiver request.

Tennessee Department of Finance and Administration

By : _____
Signature of Administrator Date

Name of Hospital

By : _____
Assistant 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:

_____ Contact name:
_____ Telephone no:

FOR STATE USE ONLY

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