



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

MCC
Instate and Out-Of-State Group 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.

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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MCC CHECKLIST
Instate and Out-Of-State Group Provider

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) _____

No. 3 Group Application _____

Disclosure of Ownership (Required) _____

Substitute W-9 Form _____

DEA Certification (If Applicable) _____

CLIA Certification (If applicable) _____

Copy of License (If Applicable) _____

Copy of Certification (If Applicable) _____

Copy of Accreditation (If Applicable) _____

Copy of Renewal (If Applicable) _____

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

NOTE: THIS FORM MUST BE RETURNED WITH THE ENROLLMENT PACKET

NO 3 GROUP 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"/> Clinics <input type="checkbox"/> OPT/SP <input type="checkbox"/> X-Ray (Portable X-rays)	<input type="checkbox"/> Group <input type="checkbox"/> Labs <input type="checkbox"/> Ambulatory Surgical Ctr.	<input type="checkbox"/> EMS <input type="checkbox"/> CORF <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: _____

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