TENNESSEE CHILDREN’S SPECIAL SERVICES (CSS) PROGRAM

LETTER OF AGREEMENT
(July 2018)

I, __________________________________________________________, representing
(Print Full Name)

_______________________________________________________________________
(Print Name of Business)

I would like to serve as a Provider for the Children’s Special Services Program. Pursuant to
program guidelines, I agree to provide the agreed services for eligible participants and abide by
the following conditions as applicable:

- Requests for services shall be submitted to the CSS Regional/Metro Coordinator for prior
  approval or authorization.

- All medical/diagnostic reports shall be sent to the designated CSS Regional/Metro Coordinator.

- Providers shall provide proof of licensure, certification and/or accreditation if applicable.

- Providers shall agree to accept the reimbursement rates for CPT codes used by the CSS
  program.

- Providers shall agree to acceptance of payments as listed in the CSS fee schedule and
  subsequently seek outstanding payment(s) from CSS enrollee if the service(s) are not covered by
  CSS.

- The requested service or procedure **must** be related to the CSS eligible diagnosis and **must**
  be medically necessary.

- Providers shall submit a treatment plan to the CSS Regional/Metro Coordinator.

  The admitting treatment plan shall include the following:
  - Diagnosis for which the service or procedure is requested.
  - Diagnostic or surgical procedure with the appropriate CPT codes.
  - Any appliances or equipment for which there will be an additional charge.
  - Anticipated length of stay.
  - Estimated Cost.

- Providers shall provide or accept a 60-day notice when a decision to terminate is made by either
  party.

- Providers shall provide written notification to the CSS Regional/Metro Coordinator of a change in
  physical or billing address within thirty (30) days. In addition, any changes in Tax ID will be
  submitted to the CSS Central Office within thirty (30) days.

- Providers in the CSS provider network who provide service to CSS eligible participants may not
  submit to the family concurrent charges over and above the amount reimbursed by third party
  payers and/or the CSS program. This does not preclude a family or other party from making a
  contribution towards the care of the child when they are willing and able, but such contribution
  shall not be solicited or accepted from the family of a child on TennCare for services covered in
  whole or in part by TennCare or other state insurance plans.
I fully understand and agree with all conditions evidenced by the information provided below:

Provider (Taxpayer Name): ________________________________________________________

Tax ID#: _________________________________________________________

Physical Address: _________________________________________________________
(Actual physical address of business)

Phone: (______) _________________________________

Fax: (______) _________________________________

Email: ______________________________________________________________________________

License Information
Have you ever been convicted of a felony? ______ Yes ______ No (If yes, please explain below)
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever been investigated by any regulatory authority or subjected to disciplinary action by any agency or hospital? ______ Yes ______ No (If yes, please explain below)
____________________________________________________________________________________
____________________________________________________________________________________

_______ (Check to confirm document is attached) Copy of the State License for Facility and/or Health Care Provider is attached.

Release Statement

I certify that the information I am providing in this Letter of Agreement is correct and complete to the best of my knowledge. I hereby give permission to the Tennessee Department of Health to request and obtain references or reports of any information from present or previously affiliated individuals or institutions, if needed in considering my application as a service provider to the Children’s Special Services Program. I hereby release any previously affiliated individual or institution from liability in providing information needed by the Tennessee Department of Health for the purpose of considering this application.

Signature: _______________________________________________________________

Name: (printed) ___________________________________________________________

Title: _________________________________________________________________

Date: _________________________________________________________________

Remittance Address: _______________________________________________________
(Address for payment if different from business address)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

TN CSS Program Letter & Agreement (July 2018)
REV. 02/01/18