TENNESSEE CHILDREN'S SPECIAL SERVICES (CSS) PROGRAM
LETTER OF AGREEMENT
(July 2021)

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 may seek outstanding payment(s) from CSS enrollee if the service(s) are not covered by CSS or other third party payor sources.
- 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 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: _____

Federal Debarment Information

Is the provider currently debarred/ineligible to receive federal funds?____Yes____No
* If yes, the provider is not eligible for participation in this program. If provider is debarred any time after signing letter of agreement they are required to notify the TN Department of Health, Division of Family Health and Wellness immediately.

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)
_____
_____
_____