INSTRUCTION PAGE

South Carolina Medicaid Provider Enrollment

Physician and Midlevels – Complete:

Regarding Required Disclosures - Part I

Midlevels Only – Also complete:

Individual Medicaid Enrollment Data Other Medical Professionals

Have your supervising physician to complete the Preceptor/Protocol Agreement Form

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES
Part 1

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

☐ **Yes** ☐ **No**

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

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2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name: First	M.I.	Last	Suffix / Title (MD, etc.)
*SSN:	*Date of Birth (mm/dd/ccyy): / /		*Gender:
Provider Number: (If Known)	*NPI:	Email address:	
*Primary Practice Location Name and Address:		*Telephone Number:	

Name Street Address City State Zip + 4

Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? ☐ **Yes** ☐ **No**

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction.
(Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____

*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

South Carolina Department of Health and Human Services

MAIL COMPLETED FORM TO:
Medicaid Provider Enrollment
Post Office Box 8809
Columbia, South Carolina 29202-8809

INDIVIDUAL MEDICAID ENROLLMENT DATA
OTHER MEDICAL PROFESSIONALS

Enrollment Date: MO – DAY – YR

SHADED ITEMS ARE FOR AGENCY USE ONLY AND NO INFORMATION SHOULD BE ENTERED BY THE MEDICAID PROVIDER.

ITEMS IN **BOLD CAPITALS** MUST BE COMPLETED OR THIS FORM WILL BE RETURNED TO YOU.

ITEMS MARKED WITH AN ASTERISK (*) SHOULD BE COMPLETED BASED ON THE CODES LISTED ON THE ATTACHMENT TO THIS FORM.

1 Medicaid No.

2 Provider Type 19

3 1099 Indicator Y

4 Sort Key

5 PROVIDER'S NAME

6 PROVIDER'S SOCIAL SECURITY NO.

7 IRS Tax Payer Employer Identification Name (Sole Proprietor--ONLY)

8 IRS Employer ID No. (Sole Proprietor--ONLY)

BUSINESS PRACTICE LOCATION ADDRESS (PHYSICAL LOCATION)

9 NUMBER AND STREET

10 CITY

11 STATE

12 ZIP + 4 –

Payment Address (If different from Business Practice Location address)

13 In care of, Attention, Building Name, etc.

14 Number and Street or PO Box

15 City

16 State

17 Zip + 4 –

Mailing Address

18 Number and Street or PO Box

19 City

20 State

21 Zip + 4 –

22 COUNTY*

23 TELEPHONE (INCLUDE AREA CODE) ( ) –

24 Type Ownership 002

25 EC Ind. X

26 Medicare ID No.

27 LICENSE NO.

28 LICENSE ISSUE DATE – –

29 STATE LIC. BOARD*

30 PRACTICE SPECIALTY (Enter Two Digit Code)

- 04 - Audiologist
- 06 - Certified Nurse Midwife/Licensed Midwife
- 25 - Certified Registered Nurse Anesthestist or Anesthetist Assistant
- 82 - Psychologist
- 84 - Speech Pathologist
- 85 - Physical Therapist
- 86 - Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant
- 87 - Occupational Therapist
- LT - Licensed Marriage & Family Therapist
- PC - Licensed Professional Counselor
- SW - Licensed Independent Social Worker - CP

31 Group Numbers

If a member of a Group Practice, enter ID number assigned by Medicaid

32 CLIA Number

Cert. Type*

Effective Date – –

Expiration Date – –

Attach Copy of CMS CLIA Certificate

33 NPI NO.

34 NPI ISSUE DATE – –

35 TAXONOMY CODE

36 Enroll Status

37 Enroll Date – –

ATTENTION: A statistically valid random sampling technique with extrapolation may be used for determining overpayments/underpayments to medical providers.

I certify that I have read the conditions of participation and payment on the reverse side of this form, that I understand and agree to the conditions of participation on the reverse side of this form, that the enrollment information I have furnished is true, accurate, and complete and that I will report any change affecting my enrollment. I further certify that I will obtain authorization from each Medicaid patient to release to SCDHHS medical information necessary for processing Medicaid claims.

Print Name and Title of Authorized Agent: _____

SIGNATURE AUTHORIZED AGENT: _____ Date _____
A facsimile stamp is not acceptable.

AS A CONDITION OF PARTICIPATION AND PAYMENT, I UNDERSTAND AND AGREE;

- That this agreement shall not be assigned or transferred.
- That upon acceptance of this agreement, the South Carolina Department of Health and Human Services (SCDHHS) will issue a Medicaid provider number, which must be used in filing all claims.
- That services shall be provided to Medicaid recipients in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, as amended, and the Age Discrimination Act of 1975 and any regulations promulgated pursuant to any of these Acts.
- In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et seq.) and regulations pursuant thereto, (45 CFR Part 80, 1996. as amended). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000 et. seq.) and its implementing regulation at 45 CFR Part 80, the provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- That adequate and correct fiscal and medical records shall be kept to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations, and policies.
- That all fiscal and medical records shall be retained for a period of three (3) years after last payment was made for services rendered. If any litigation, claim, audit, or other action involving the records has been initiated prior to the expiration of the three (3) years, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the three (3) year period, whichever is later.
- That, for the purposes of reviewing, copying, and reproducing documents, access shall be allowed to all records concerning services and payment under this agreement to the SCDHHS, the State Auditor's Office, the South Carolina Attorney General's Office, the Department of Health and Human Services and/or their designee during normal business hours.
- That upon request, information must be furnished regarding any claim for payment to the SCDHHS.
- That requests for reimbursement for services shall reflect any third party payment received and that any payment received subsequent to claims filing shall be reported.
- That Medicaid will reimburse the co-insurance and/or deductible portions (cost sharing) of Medicare claims for recipients with both coverages only if the provider accepts Medicare assignment. Cost sharing is limited by the Medicaid allowed amount for the service.
- That Medicaid reimbursement is always made to the provider of services and that the recipient shall not be billed pending receipt of such payment.
- That Medicaid reimbursement is payment in full and that the provider shall not bill, request, demand, solicit, or in any manner receive or accept payment from the recipient or any other person, family member, relative, organization or entity for care or services to a recipient/patient except as may otherwise be allowed under Federal regulations or in accordance with SCDHHS policy.
- That this statement applies only to those recipients for whom Medicaid claims are filed and that it in no way requires that the provider render services to any Medicaid recipient.
- Either party may terminate this agreement upon providing the other party with thirty (30) days written notice termination. Such termination shall be sent by Certified Mail, Return Receipt Requested, and be effective thirty (30) days after the date of receipt.
- That the provider shall disclose full and complete information as to ownership, business transactions, and criminal activity in accordance with 42 CFR 455.104 through 455.106 (1999). Furthermore, the provider shall disclose any felony convictions under Federal or State law in accordance with 42 CFR 1001.101 Subpart B through 1001.1701 Subpart C (1999).
- That, for any dispute arising under this agreement, the provider shall have as his sole and exclusive remedy the right to request a hearing from SCDHHS within thirty (30) calendar days of the Commission action which he believes himself aggrieved. Such proceedings shall be in accordance with SCDHHS appeals procedures and S.C. Code Ann. 1-23-310 et. seq. (1976, as amended). Judicial review of any final agency administrative decision shall be in accordance with S.C. Code Ann. 1-23-380 (1976, as amended).
- That the provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX (Medicaid) services in accordance with 42 CFR Part 431 Subpart F (1991), SHHSFC's regulation R.126-170, et seq., Code of Laws of South Carolina (1976) Volume 27 as amended, and all applicable State laws and regulations.
- That none of the funds provided under this agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for political office, or otherwise in violation of the "Hatch Act".
- That all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with SCDHHS policies, procedures, and Medicaid Provider Manuals.
- That all information provided on the Medicaid enrollment form is incorporated as a part of this agreement.
- That the provider shall be held personally liable for all claims submitted by him or on his behalf as evidenced by his endorsement of his Medicaid reimbursement check.
- That Medicaid reimbursement (payment of claims) is from state and federal funds and that any falsification (false claims, statement or documents) or concealment of material fact may be prosecuted under applicable state and federal laws.
- That the provider must comply with all requirements of the Americans with Disabilities Act of 1990 (ADA), as applicable.
- That the provider shall comply with all terms and conditions of the Drug Free Workplace Act, S.C. Code Ann. Section 44-107-10 et seq. (1976, as amended) if this agreement is for a stated or estimated value of Fifty Thousand Dollars or more.
- That in accordance with 31 U.S.C. 1352, funds received through this agreement may not be expended to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement. This restriction is applicable to all contractors and subcontractors.
- The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification: Standard Unique Health Identifier for Health Care Providers regulations (42 CFR 165 Subparts A & D), states that all covered entities: health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES) no later than May 23, 2007.
- Pursuant to the Standard Unique Health Identifier regulations (42 CFR 165 Subparts A & D), and if the provider is a covered health care provider as defined in 42 CFR §162.402, the provider agrees to disclose its NPI to SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

State of South Carolina
Department of Health and Human Services

PRECEPTOR/PROTOCOL AGREEMENT FORM

1. A Nurse Practitioner, Nurse Midwife, Clinical Nurse Specialist, or Physician Assistant practicing in an extended role shall perform delegated medical acts pursuant to an approved written protocol between the nurse or physician assistant and the physician.

2. The approved written protocol shall include the following information at a minimum:

   A. General Data:

      1. Name, address, and license number of the nurse or physician assistant.
      2. Name, address, and license number of the physician preceptor/collaborator.
      3. Nature of practice and practice location(s) of the nurse or physician assistant and the physician.
      4. Date the protocol was developed and dates reviewed and amended.
      5. Description of how consultation with the physician is provided and if a provision for backup consultation has been established in the physician's absence.

   B. Delegated Medical Acts:

      1. The medical conditions for which therapies may be initiated, continued or modified.
      2. The treatments that may be initiated continued or modified.
      3. The drug therapies that may be prescribed.
      4. Situations that require direct evaluation by or referral to the physician.

3. The original protocol and any amendments to the protocol, dated and signed by the nurse or physician assistant and the physician, shall be available for review within 72 hours of request.

4. Individuals, who change practice settings or physicians, shall notify the Department of Health and Human Services (DHHS) in writing within 15 days. Individuals who discontinue their practice shall notify DHHS in writing within 15 days.

I, the undersigned, agree to serve as the physician preceptor/collaborator for _____ _____. My preceptorship is to extend to the limits described in the above written protocol.

Date_____

_____ Physician Signature

_____ Enrollee Signature

_____ Physician License #

_____ Physician Assistant or Nurse License #

PLEASE RETURN THIS AGREEMENT FORM WITH YOUR ENROLLMENT FORM

06/04