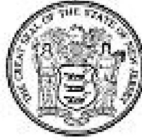


STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHYSICIAN/GROUP (NJAC 10:54 et seq.)

Application package consists of:

1. Application Cover Letter
2. **Request for National Provider Identifier (NPI) (required)**
3. Signature Authorization Form
4. Provider Start Date Form
5. Notice to all applicants
6. FD-23 - Group Practice Application
7. W-9 Tax Form (required)
8. **Notice to Enrollee (documentation required)**
9. Affirmative Action Survey (optional)
10. **Authorization for Automatic Payments & Deposits (required)**
11. Agreement of Understanding

In order to be an approved Physician Group, applicant must submit a completed application package including the following:

1. Copy of license from the N.J. State Board of Medical Examiners or comparable license from an out-of-state agency.
2. Copy of board certification or board eligibility letter for specialists. **SPECIALIST**, for purposes of the New Jersey Medicaid Program, means a fully licensed physician who:
   1. Is a diplomate of the appropriate American board, or Osteopathic board; or
   2. Is a fellow of the appropriate American specialty college, or a member of an Osteopathic specialty college; or
   3. Has been notified of admissibility to examination by the appropriate American board, or Osteopathic board, or has evidence of completion of an appropriate qualifying residency approved by either the American Medical Association, the Accreditation Council for Graduate Medical Education or American Osteopathic Association; or
   4. Holds an active staff appointment with specialty privileges in a voluntary or governmental hospital which is approved for training in the specialty in which the physician has privileges; or
   5. Is recognized in the community as a specialist by his peers.
      "Specialist in family practice or general practice", for purposes of the New Jersey Medicaid Program, means a fully licensed physician who is a Diplomate of the American Board of Family Practice, or a Diplomate of the American Osteopathic Board of General Practice.
3. If applicable, copy of CLIA Certification for laboratory.
4. Copy of all DEA drug permits, if applicable.
5. **You are required to submit a copy of the Social Security Card for each individual practitioner in the group practice as their Social Security Number is the primary means of identity.**

PRACTITIONERS EMPLOYED BY PHYSICIAN GROUP(S) / CLINICS

The enclosed W-9 Tax Form is required for all enrollments. Please indicate the name of the individual, group, or facility as registered with the IRS.

If all components are present and complete, the Physician/Group may be approved for participation by DXC Technology.

The effective date of approval will be either the date of the Provider Agreement or the date on the Provider Start Date Form, whichever date is earlier.

NOTE: In order to add a Nurse-Midwife to a Physician Group/Clinic, applicant must include the following:

1. Copy of New Jersey Board of Medical-Examiners License.
2. Copy of American College of Mid-Level Practitioner Certification.

NOTE: In order to add an Advanced Practice Nurse to a Physician Group/Clinic, applicant must include the following:

1. Copy of registered professional nurse license from the New Jersey Board of Nursing.
2. Copy of New Jersey Board of Nursing certification for Advanced Practice Nurse.
3. Copy of American Nurses Credentialing Center Certification.

NOTE: Out-of-state Advanced Practice Nurse must submit equivalent documentation.

NOTE: Some licenses may still use the terminology Registered Nurse Practitioner or Registered Nurse, Certified Nurse Specialist.

Application Cover Letter

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Dear Provider:

Your request for a Provider Specific Enrollment Packet has been received and documented. We are mailing you the packet of forms needed to meet enrollment requirements for your provider type. Please complete the forms and make sure all questions are answered; where not applicable, just enter N/A. Otherwise, there will be a delay in the enrollment process.

Other attachments required for your provider type are listed on the preceding page.

Your promptly completed enrollment packet will ensure a speedy enrollment process. If you have not received any correspondence within a month, please write to:

Provider Enrollment
DXC Technology
P.O. Box 4804
Trenton, NJ 08650

Provider Enrollment Unit
609-588-6036

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

Notice to Enrollee(s)

In an effort to properly set-up the identity of an individual or an entity as a NJ Medicaid provider the Division requires that when a social security number is the primary means of identity you are required to submit a copy of your social card.

If you are an entity, you are required to submit a copy of your 147C letter from the IRS or copy of the IRS CP-575 form.

PLEASE BE ADVISED THAT YOUR APPLICATION TO BECOME A NJ MEDICAID PROVIDER CANNOT BE COMPLETED UNTIL WE HAVE RECEIVED A COPY OF THESE DOCUMENTS.

Request for National Provider Identifier (NPI)
Provider Enrollment Application Insert

You must have an NPI number to bill electronically. To obtain an NPI number, please provide us with the information requested in the boxes below and return this form along with your completed enrollment application. Failure to do so will slow the enrollment process.

The Center for Medicare & Medicaid Services (CMS) established a May 23, 2007 deadline for implementing NPI provisions. On April 2, 2007, CMS extended the deadline to May 23, 2008. However, it is the intention of the State of New Jersey to establish a Statewide Deadline for requiring compliance with all NPI provisions before May 23, 2008. The Division of Medical Assistance & Health Services (DMAHS), in cooperation with other State agencies, will notify providers regarding the Statewide Deadline for compliance with NPI provisions when transmitting a health care claim for payment as a standard electronic HIPAA transaction or paper claim.

The NPI shall replace the billing and servicing provider number previously used to bill Medicare, New Jersey FamilyCare (NJFC)/Medicaid, and other health care payers.

All health care providers can apply for an NPI:

- Using the web-based application https://nppes.cms.hhs.gov; or

- Sending a paper application to the Center for Medicare & Medicaid Services' (CMS') NPI Enumerator, Fox Systems. A copy of the application can be downloaded at https://nppes.cms.hhs.gov. A health care provider can also contact the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

Name	Address	NPI Number
1)		
2)		
3)		

SIGNATURE AUTHORIZATION FORM

Date:

Dear Provider:

If anyone other than the practitioner is authorized to sign and certify Medicaid claims and supporting documents, the signature of that person must appear on the claim form as indicated below (**NOT THE PRACTITIONER'S NAME**). If the authorized individual is the Medicaid Provider, he/she must sign the Authorization Form.

In addition to the above, an authorized representative(s) who is an employee of your office should **only** complete this form. Should your office utilize a billing firm or agency, a letter signed by yourself must be submitted indicating the name(s) of those individuals you have authorized to sign. The name(s) should be printed and then the actual signature affixed by that individual. The letter should contain the name of the billing firm or agency which has been approved to provide your billing.

If your application is for the group please provide the GROUP NAME in the Provider Name field. If the application is for an individual please provide the Individual Provider name in the Provider name field.

Note: Only Originals. No Faxes or Copies are accepted.

Provider Name:		
Provider ID #:		NPI#:
Address:		
City:	State:	Zip:

Please Print or Type	
Full Name	**Actual Signature(s)**

RETURN TO:

DXC Technology
Attn: Provider Enrollment Unit
P.O. Box 4804
Trenton, NJ 08650-4804

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Provider Start Date Form

HAVE YOU ALREADY RENDERED SERVICES TO A NEW JERSEY MEDICAID BENEFICIARY? IF SO, GIVE DATE OF SERVICE ____________________________________.

Take Note:
The above date you indicate will be the effective date of your Medicaid Provider Enrollment for claims submission. If this form is not completed, your effective date will reflect the date signed on your provider agreement.

ALSO, ATTACH A COPY OF THE PROVIDER'S LICENSE THAT SUPPORTS THE ABOVE DATE OF SERVICE. (IF APPLICABLE)

PLEASE TAKE NOTE: It is a New Jersey Medicaid Requirement (NJAC 10:49-7.2 Timeliness of Claim Submission and Inquiry) that the New Jersey Medicaid Fiscal Agent, DXC Technology, receive a provider's claim submittal within one (1) year from:

1. The date of discharge for institutional claims, or,
2. The date of service or dispensing date for non-institutional claims.

Please also refer to the billing manual you will receive from the Fiscal Agent when a provider number is assigned for further claim submittal instructions.

For DXC Technology Internal Use Only

Provider Name: ____________________

Doc Type: ____________ Provider Type: ________ Provider Specialty: ________

Tax ID: ____________ Social Security: ____________

Provider Number: ____________

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services (DMAHS)

GROUP PRACTICE APPLICATION

(For new groups, for adding new members to existing groups, include all Professional Corporations, Associations and Practitioners using trade names.)

If Transfer of Ownership, what is the 7 digit Medicaid provider # ____________and Tax Id ______________ of the previous owner.

1. New Group Effective Date____________________ 2. Group Medicaid Provider No.______________
(Complete when adding new member(s) to an existing group)

3. Type of Group:________________(e.g. Medical, Dental, Psychologist, Optometrist, Pediatric, etc.)

4. Legal Name of Group______________________________

5. List the name, birth date, social security #s of any person(s) who has more than 5% direct or indirect ownership of the group practice, if a non-profit, board members would be appropriate (use separate sheet of paper is necessary):

a. ______________________________

b. ______________________________

c. ______________________________

5A. List whether any individual or entity with an ownership or control interest in the group practice is related to another individual with ownership or control interest in the group practice as a spouse, parent, child, or sibling; or whether any individual or entity with an ownership or control interest in any subcontractor in which the group practice has a 5 percent or more interest is related to another individual with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling (use separate sheet of paper if needed).

a. ______________________________

b. ______________________________

c. ______________________________

5B. Please disclose the following: (1) The ownership of any subcontractor with whom the group practice has had business transactions totaling more than $25,000 during the previous 12 months; and (2) Any significant business transactions between the group practice and any wholly owned supplier, or between the group practice and any subcontractor, during the previous 5 years.

____

____

5C. List the name, birth date, social security #s of, agent(s), administrator(s) and managing employees: (use separate sheet of paper if needed)

a. ______________________________

b. ______________________________

c. ______________________________

6. **Practice Address**

Street: ____

City: ____

State: _____________ Zip: _________ County: _____________

7. **Pay To Address** (For Checks/Remittance Advice)

Street: ____

City: ____

State: _____________ Zip: _________ County: _____________

8. **Mail To Address** (For Newsletters/Correspondence)

Street: ____

City: ____

State: _____________ Zip: _________ County: _____________

9. Group Tax ID________________________ 10. Group Ownership__________________________________
(Specify Corp., Partnership, etc.)

11. Office Phone #/Ext.__________________ 12. Contact Person____________________________________

13. Billing Phone/Extension#__________________ 14. Fax______________________________________

15. Group Medicare #________________________ 16. Group NPI #______________________________

17. E-mail Address____

18. Group CLIA #______________________ 19. Mammography Cert.________________________________
(if applicable) (if applicable)

---

20. List Practitioners to be added to the Group:

A. Practitioner Name____ Degree__________ SS#_________________

Specialty __________ __________ __________ NJ/Out-of-State License #_______________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #______________ UPIN #____________________

___ No ___ No NPI #__________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #________________ DEA Permit Number________________

Effective Date Requested__________________ Date of Birth______________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

B. Practitioner Name____ Degree__________ SS#_________________

Specialty __________ __________ __________ NJ/Out-of-State License #________________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #______________ UPIN #____________________

___ No ___ No NPI #_________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #________________ DEA Permit Number________________

Effective Date Requested__________________ Date of Birth_______________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

C. Practitioner Name_______________________________________ Degree__________ SS#_________________

Specialty __________ __________ __________ NJ/Out-of-State License #________________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #______________ UPIN #____________________

___ No ___ No NPI #_________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #________________ DEA Permit Number________________

Effective Date Requested__________________ Date of Birth_______________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

D. Practitioner Name_______________________________________ Degree__________ SS#_________________

Specialty __________ __________ __________ NJ/Out-of-State License #________________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #______________ UPIN #____________________

___ No ___ No NPI #_________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #________________ DEA Permit Number________________

Effective Date Requested__________________ Date of Birth_______________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

E. Practitioner Name_______________________________________ Degree__________ SS#_________________

Specialty __________ __________ __________ NJ/Out-of-State License #________________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #______________ UPIN #____________________

___ No ___ No NPI #________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #_______________ DEA Permit Number_______________

Effective Date Requested_________________ Date of Birth_____________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomate of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

F. Practitioner Name_____________________________________ Degree__________ SS#________________

Specialty __________ __________ __________ NJ/Out-of-State License #______________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #_____________ UPIN #___________________

___ No ___ No NPI #________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #_______________ DEA Permit Number_______________

Effective Date Requested_________________ Date of Birth_____________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

G. Practitioner Name_____________________________________ Degree__________ SS#________________

Specialty __________ __________ __________ NJ/Out-of-State License #______________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #_____________ UPIN #___________________

___ No ___ No NPI #________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #_______________ DEA Permit Number_______________

Effective Date Requested_________________ Date of Birth_____________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomate of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

---

H. Practitioner Name_____________________________________ Degree__________ SS#________________

Specialty __________ __________ __________ NJ/Out-of-State License #______________________________

Bd. Cert. ___ Yes Bd. Eligible ___ Yes Medicare #_____________ UPIN #___________________

___ No ___ No NPI #________________

(Attach copy of Certification) (Attach Documentation)

Existing Medicaid Provider #________________ DEA Permit Number________________

Effective Date Requested__________________ Date of Birth_______________________

FOR DENTISTS ONLY:

1. Are you authorized to administer general anesthesia? ___ Yes (attach a copy) ___ No
2. Are you a diplomat of a specialty board recognized by ADA? ___ Yes (attach a copy) ___ No
3. Do you meet minimum requirements of that specialty as stipulated by the ADA? ___ Yes (attach a copy) ___ No

*** Every item must be completed and further explained, if required.**

21. Have any of the individuals or entities required to be named in response to any questions in this application, or their officers, directors, shareholders, members, owners, partners, agent(s), administrator(s), employees or managing employees:

  a. Ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? ____ Yes ____ No. If yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

  b. Ever been the subject of any past or pending license suspension, revocation, or other adverse action by any licensing authority, including but not limited to any fine, penalty, reprimand, disciplinary action or probationary period (even if paid and/or resolved) imposed by any licensing authority (excluding motor vehicle violations), in this state or any other jurisdiction? Yes ____ No _____ If Yes, explain:

  c. Ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime or disorderly persons offense in this State or any other jurisdiction (even if this resulted in pre-trial intervention)? Yes ____ No ____ if yes, explain:

  d. Ever been the subject of any past or pending suspensions, debarments, disqualifications, recovery action or criminal convictions involving Medicaid, Medicare or any other federally-funded or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DMAHS? Yes ____No ____ If yes, explain, and indicate current status of action:

  e. Does any person (or any member of such person's immediate family) or entity required to be named in response to any questions in this application ever owned or had any interest in, or any relationship (including an employment relationship) with, any other corporation, partnership or other entity providing services under Medicaid, Medicare, or any other federally or state-funded health care program, or any private or non-profit health insurance plan or program in this state or in any other jurisdiction? Yes___ No___ If yes, explain:

22. Is any individual required to be named in this application a current or former full or part-time employee of the state of New Jersey? Yes ___ No ____ If yes, explain, and if currently employed, list the hours and days of employment.

23. N.J.A.C.10:49.4.1 defines a "shared health care facility" as…"four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and 1. Two or more of whom share any of the following; i. Common waiting areas; ii. Examining rooms; iii. Treatment rooms; iv. Equipment; v. Supporting Staff; vi. Common records; and 2. One or more of whom receives payment on a fee-for-service basis, and where the gross Medicaid income for the facility meets or exceeds $80,000.00 per year."

    Does your group participate in a shared health care facility as defined above?____Yes____No. If yes, please explain.

NOTE: For purposes of this question, staff employed by an independent freestanding clinic(s) are not considered "providers".

24. **NOTE:** There are federal and state statutes and regulations governing kickbacks and referral practices which may apply to the applicant and to those individuals and entities listed in this application. These statutes and regulations include, but are not limited to: The Federal Medicare and Medicaid Anti-Kickback Statute (42 USC 1320a-7b(b)); the Federal Safe Harbor Regulations (42 CFR 1001.952); the Stark Laws (42 USC 1395nn, 42 USC 1396b(s) and implementing regulations); the State Medicaid Anti-Kickback Statute (NJS 30:4D-17(c)); and the Code Law (NJSA 45:9-22.4 et. seq.) and its implementing regulations (NJAC 13:35-6.17)). Applicants should carefully review and understand these legal requirements and prohibitions, because signing this Agreement is a representation that there is full compliance with all of these statutes and regulations.

25. FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO BENEFICIARIES UNDER THE NEW JERSEY MEDICAID (TITLE XIX) PROGRAM AND THE OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS), I CERTIFY ON BEHALF OF THE APPLICANT THAT THE INFORMATION FURNISHED IN THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE. I AM AWARE, AND BY SIGNING THIS APPLICATION GIVE CONSENT ON BEHALF OF THE APPLICANT THAT I REPRESENT, THAT DMAHS AND/OR THE MEDICAID FRAUD DIVISION (MFD) OF THE OFFICE OF THE STATE COMPTROLLER MAY VERIFY THE ACCURACY OF ANY AND ALL INFORMATION AND DOCUMENTATION SUBMITTED IN CONNECTION WITH THIS APPLICATION, INCLUDING, BUT NOT LIMITED TO, CONDUCTING A CIVIL AND/OR CRIMINAL BACKGROUND INVESTIGATION RELATING TO ANY OF THE INDIVIDUALS OR ENTITIES MENTIONED IN THIS APPLICATION OR IN ANY SUPPORTING DOCUMENTS. I AM AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE FALSE OR FRAUDULENT, OR IF THE RESULTS OF THE BACKGROUND INVESTIGATION ARE UNSATISFACTORY, THIS APPLICATION MAY BE DENIED, AND I AND THE APPLICANT ARE SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO: CRIMINAL PROSECUTION UNDER APPLICABLE STATUTES, INCLUDING N.J.S. 30:4D-17 AND N.J.S. 2C:28-3; SUSPENSION, DEBARMENT OR DISQUALIFICATION FROM THE NEW JERSEY MEDICAID PROGRAM AND ALL OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY DMAHS IN ACCORDANCE WITH N.J.A.C. 10:49-11.1(D)22; TERMINATION OF ANY PROVIDER AGREEMENT UNDER N.J.A.C. 10:49-3.2(F); AND RECOVERY UNDER APPLICABLE STATUTES AND REGULATIONS, INCLUDING N.J.S. 30:4D-7.H. AND N.J.S. 30:4D-17. I ALSO UNDERSTAND THAT ALL OF THE QUESTIONS IN THIS APPLICATION MUST BE ANSWERED, AND THAT FAILURE TO DO SO MAY RESULT IN DENIAL OF THIS APPLICATION. I FURTHER UNDERSTAND THAT IF THIS APPLICATION IS DENIED, A NEW APPLICATION CANNOT BE RESUBMITTED FOR A PERIOD OF ONE YEAR FROM THE DATE OF THE DENIAL. I AGREE TO NOTIFY (IN WRITING) THE FISCAL AGENT'S PROVIDER ENROLLMENT UNIT IMMEDIATELY OF ANY UPDATES OR CHANGES TO ANY OF THE INFORMATION THAT ARE BEING PROVIDED IN THIS APPLICATION AND IN ANY SUPPORTING DOCUMENTS. .

Signature	Print Name	Title	Date

Notice To All (Licensees of the Board of Medical Examiners)

Please note that regulations promulgated by the NJ State Board of Medical Examiners at N.J.A.C. 13:35 - 2.6(d) require that a medical practice be owned only by licensed practitioners; except as provided in N.J.A.C. 13:35 - 6.16(f).

Any individual or entity violating these regulations will be subject to appropriate sanctions contained in applicable statutes and regulation, including but not limited to exclusion from the Medicaid program. Any individual or entity found violating these regulations will be referred to the NJ State Board of Medical Examiners.

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
NEW JERSEY HEALTH SERVICES PROGRAM TITLE XIX (MEDICAID)
NJ FAMILYCARE PROGRAM TITLE XXI

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

____
Provider's Name (Group Name)

PROVIDER AGREES (All group members must read and sign the provider agreement):

1. To comply with all applicable State and Federal "Medicaid" laws and policy; and rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid and all other programs administered in whole or in part by DMAHS;

3. To furnish DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Section for the Division of Criminal Justice with such information as may be requested from time to time regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS without charges for copies, and without any fees for compiling the requested information.

4. To notify the Division of Medical Assistance and Health Services, in writing, within ten (10) working days of any change in the group membership (e.g., addition of a new practitioner, loss of a practitioner, change in practitioner's specialty status).

5. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.)

6. To comply with the disclosure requirements specified in 42CFR 455.100 through 42CFR 455.106.

7. To accept Title XIX payment as payment in full and not institute collection activities, including but not limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c.

THE PROVIDER OR DMAHS MAY, ON (60) DAYS WRITTEN NOTICE TO THE OTHER PARTY, TERMINATE THIS AGREEMENT.

	Date	Print Name	Signature of Practitioner
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			

NOTE: Providers must date and sign this agreement.

Person completing this application:

DATE	PRINT NAME	SIGNATURE

Form **W-9**
(Rev. December 2000)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Please print or type

Name (See **Specific Instructions** on page 2.)

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▸ ___________________

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II For U.S. Payees Exempt from Backup Withholding (See the Instructions on page 2.)

▸

Part III Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person ▸** **Date ▸**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to back up withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willingly falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal Law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Care, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site at **www.irs.gov**.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other type of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN* ***or*** *that you intend to apply for one soon.*

Part II-For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III-Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items.1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole Proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

AFFIRMATIVE ACTION SURVEY (OPTIONAL)

Dear Provider:

The Department of Human Services, Division of Medical Assistance and Health Services, which administers the New Jersey Medicaid Program, is conducting an Affirmative Action Survey of its participating providers.

This survey is being used as a tool to better understand the diversity of our provider network and the needs of our clients. The completion of this survey is voluntary. The statistical data from this survey will be used for Affirmative Action purposes only and will be maintained separately from all other types of information.

Please refer to definitions below and check or fill in appropriate responses in space indicated:

From N.J.A.C. 4A:7-1.1(D):

"White, Not of Hispanic Origin"	Means persons having origins in any of the original Peoples of Europe, North Africa or the Middle East
"Black, not of Hispanic Origin"	Means persons having origins in any of the Black Racial Groups of Africa
"Hispanic"	Means persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish Culture or origin, regardless of race.
"American Indian or Alaskan Native"	Means persons having origins in any of the original Peoples of North America, and who Maintain cultural identification through Tribal Affiliation Community Recognition.
"Asian or Pacific Islander"	Means persons having origins in any of the original Peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

1. How many direct service providers are of the following racial or ethnic background?

_____White ______Black _____Hispanic ______American Indian

_____Asian

2. How many of your support staff are of the following racial or ethnic background?

_____White ______Black _____Hispanic ______American Indian

_____Asian

3. How many of service provider(s) speak the following languages?

_____English ______Spanish Please list language & numbers

____________ _______
____________ _______
____________ _______

4. How many of the support staff speak the following languages?

_____English ______Spanish Please list language & numbers

_____________ _______
_____________ _______
_____________ _______

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

I (we) hereby authorize DXC Technology, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME ______________________ **BRANCH** ______________________

CITY ______________________ **STATE** __________ **ZIP** __________

BANK TRANSIT/ABA NO ______________________ **ACCOUNT NO.** ______________________

This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME ______________________
(Print account name exactly as it appears on your statement)

PROVIDER NAME ______________________

PROVIDER NO. ______________________ **TELEPHONE NO.** ______________________

NPI # ______________________

ADDRESS ______________________

____

____

______________________ ______________________ **DATE** ____/____/____

Printed Name Signature

______________________ ______________________ **DATE** ____/____/____

Printed Name Signature

REMARKS ______________________

____

NOTES:

1. To insure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. If a joint account, both owners must sign request form.
3. New Jersey Medicaid payments are deposited to your account each Friday at 9:00 a.m.
4. Once DXC Technology has received a **completed** authorization for payments/deposits, it will take approximately 4 weeks before the first deposit is completed electronically to your account. To verify this information, please call your bank and specifically ask for the **ACH Department**.
5. For those providers who previously had Direct Deposit, you will now receive paper checks until the new information is processed.
6. Please make a copy of this before mailing to DXC Technology.

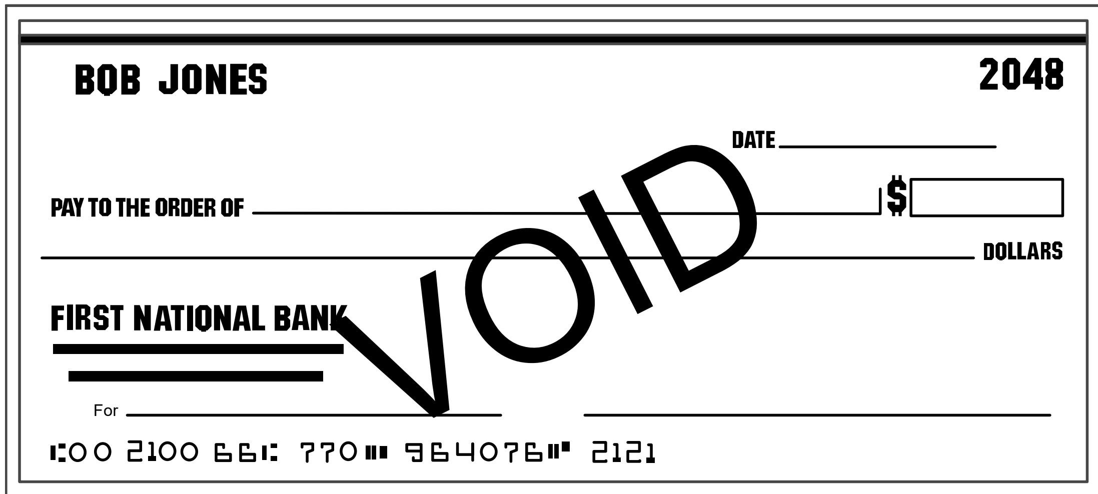
PROVIDER INSTRUCTIONS FOR COMPLETING AUTHORIZATION AGREEMENT FORM

1.	DEPOSITORY NAME	Name of bank servicing your checking account.
2.	BRANCH	Name of bank branch.
3.	CITY	City or town location of bank branch.
4.	STATE	State location of bank branch.
5.	ZIP	Zip code of bank branch.
6.	BANK TRANSIT/ABA NUMBER	Bank routing number (see below, voided check example).
7.	BANK ACCOUNT NUMBER	Checking account number (see below, voided check example).
8.	BANK ACCOUNT NAME	Actual account name per your bank's records.
9.	PROVIDER INFORMATION	Provider name, Medicaid/NJ FamilyCare Provider No., telephone No., address, date prepared and signature.

MAIL THE COMPLETED AUTHORIZATION AGREEMENT AND VOIDED CHECK TO:

Provider Enrollment Unit
DXC Technology
P.O. Box 4804
Trenton, NJ 08650-4804

NOTE: Attach blank, voided check per below sample.



Bank Transit No.
(ABA No.)

Bank Account No.

Federal Regulations and NJSA Code Quoted in Provider Agreement

42 CFR 455.100

§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding--

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

42 CFR 455.101

§ 455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that--

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means--

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

42 CFR 455.102

§ 455.102 Determination of ownership or control percentages.

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

42 CFR 455.103

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.106 are met.

42 CFR 455.104

§ 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

(a) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must--

(i) Keep copies of all these requests and the responses to them;

(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.

(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

42 CFR 455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about--

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $ 25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR 455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

N.J. Stat. § 30:4D-6.c.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

REQUEST FOR PAPER UPDATES

DIRECTIONS: Enter the requested information below, sign your name, and send the completed form to the address at the bottom of this form.

Provider Name: ______________________________ Provider Number: ______________

Contact Name: ______________________________ Telephone Number: _____________

FAX Number: _________________

Mail To Address: ______________________________________

____

____

I would like to receive printed (paper) copies of updates and distributions.

____

Provider/Authorized Representative Signature

____

Date

MAIL THIS COMPLETED FORM TO:

Provider Enrollment
DXC Technology
P.O. Box 4804
Trenton, NJ 08650

OR FAX THIS COMPLETED FORM TO DXC TECHNOLOGY PROVIDER RELATIONS AT:

Fax Number: (609) 584-1192

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

CAROLE JOHNSON
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

*Agreement of Understanding

To the Person Submitting this Enrollment Packet:

I understand that upon receipt of this enrollment packet to DXC Technology, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA see NJSA Section 47:1A).

Before any documents are sent to someone requesting this information, all personal information such as tax Id and social security numbers would be redacted.

It is the responsibility of the person signing this Agreement of Understanding to convey this information to all of individuals who are named in this application to become a New Jersey Medicaid provider. Although the request for enrollment information is uncommon, it does fall under the Open Public Records Act.

I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey.

____
Sign

____
Print

____
Date

*A signed Agreement of Understanding is required before an application can be processed.

08/29/2019