

*TOC not required***141.000 Provider Enrollment****8-1-14**

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers may enroll on the Arkansas Medicaid website at <https://www.medicaid.state.ar.us>. Potential providers that are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. [View or print the Provider Enrollment contact information.](#)

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. [View or print the provider enrollment and contract package \(Application Packet\).](#)

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

- A. W-9 Tax form (DMS-652)
- B. Medicaid Provider Contract (DMS-652)
- C. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)
- D. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)
- E. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

- A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

- B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application
- C. Electronic Funds Transfer (EFT) Authorization for Automatic Deposit
- D. Change in practice or specialty
- E. Retirement or death of provider
- F. Name Change Form
- G. Change of Ownership Form (DMS-0688) ([View or print form DMS-0688 – Provider Change of Ownership Information Form.](#))
- H. Address Change Form (DMS-673) ([View or print form DMS-673 – Address Change Form.](#))
- I. Change in Ownership Control (5% or more) or Conviction of Crime ([View or print form DMS-675 – Ownership and Conviction Disclosure.](#))
- J. Disclosure of Significant Business Transactions ([View or print form DMS-689 – Disclosure of Significant Business Transactions.](#))

Criminal background checks are conducted on all applicants enrolling as Arkansas Medicaid providers. If the result of a background check reveals that an applicant was required by a court to register as a sex offender or if the applicant is listed on any state or federal website designated to track sex offenders, the applicant will be automatically and permanently excluded from providing goods and services under the Arkansas Medicaid program.

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) unless the provider is an atypical provider not required to have an NPI.

**Disclosure of Significant Business Transactions**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

*[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]*

**IMPORTANT**

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

**Full, complete and accurate disclosure of ownership and business transaction information is required. Upon request, the provider must furnish all records described in the provider contract within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, 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 transaction 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.**

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

**INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM**

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attach to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

**DEFINITIONS**

**Provider:** a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

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

**Subcontractor:** (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

**Supplier:** an individual, agency, or organization from which a provider purchases goods or 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:** 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.

**Disclosure of Significant Business Transactions**  
**DHS Division of Medical Services, Title XIX (Medicaid)**  
*[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]*

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either \$25,000 or 5 percent of a provider's total operating expenses.

**DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS**

Submit full, accurate and complete disclosure concerning the following information:

- 1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than \$25,000 during the last 12 months (12-month period ending as of the date on this application).

---

---

---

- 2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5-year period ending as of the date of this application).

---

---

---

- 3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5-year period ending as of the date of this application).

---

---

---

**Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.**

**Provider Statement:**

“By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.”

Name: \_\_\_\_\_  
(Print or Type)

Title: \_\_\_\_\_  
(Print or Type)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Ownership and Conviction Disclosure

## DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

### IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

### INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

### DEFINITIONS

**Provider:** a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

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

**Indirect ownership:** an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

**Ownership or control interest:** a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) 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; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

**Ownership Interest:** equity in the capital, stock, or profits of the disclosing entity. To determine the 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. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

**Managing employee:** a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

**Subcontractor:** (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

**Supplier:** an individual, agency, or organization from which a provider purchases goods or 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:** 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.

**Significant business transaction:** any business transaction or series of related transactions that, during any one fiscal year, exceeds either \$25,000 or 5 percent of a provider's total operating expenses.

**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, physical address and PO Box address and each location, complete Social Security Number and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

**Individuals** – for each individual listed, provide date of birth and **COMPLETE** Social Security Number

<u>Full Name</u>	<u>Date of Birth</u>	<u>Complete Primary Address and PO Box Address</u>	<u>% of Interest</u>	<u>Complete Social Security Number</u>

<u>Name</u>	<u>Address</u>	<u>% of interest</u>	<u>DOB</u>	<u>SS#</u>

**Corporations/Limited Liability Companies/Partnerships/Other Legal Entities or Organizations** – for each legal entity or organization listed, provide the Tax ID Number and submit a copy of the legal entity or organization’s IRS form SS4 and the approval letter with this application. **Companies must include each business address location with complete addresses.**

<u>Name</u>	<u>Complete Primary Address and PO Box Address with Each Business Location</u>	<u>% of Interest</u>	<u>Tax ID Number</u>

<u>Name</u>	<u>Address</u>	<u>% of interest</u>	<u>Tax ID #</u>

**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling?

-Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, print name and provide relationship.

Name	Relationship

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program?

**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

-Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, print name, address, and Tax ID Number and amount of % of interest they own.  
give other provider name and percentage of interest.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number

Name	Other Provider	% of Interest

**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

List the name, address, date of birth, and complete Social Security Number for any person who is a managing employee of the named entity. For larger corporations having more than 3 managing employees or board members, please use next page (4)\*.

<u>Name</u>	<u>Address</u>	<u>Date of Birth</u>	<u>Complete Social Security Number</u>

<u>Name</u>	<u>Address</u>	<u>DOB</u>	<u>SS#</u>

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

<u>Name</u>	<u>Offense</u>

<u>Name</u>	<u>Offense</u>

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony,



**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]


PROPOSED

**Ownership and Conviction Disclosure**  
**DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Name	Offense

**Provider Statement:**

“By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.”

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
(Print or Type) (Print or Type)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CONTRACT  
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE  
PROGRAM ADMINISTERED BY THE DIVISION OF MEDICAL  
SERVICES UNDER TITLE XIX (MEDICAID)

INSTRUCTIONS

Please ensure that the provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

**CONTRACT  
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM  
ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES  
TITLE XIX (MEDICAID)**

The following agreement is entered into between \_\_\_\_\_, hereinafter called Provider, and the Arkansas Department of Human Services, hereafter called Department:

- I. Provider, in consideration of the covenants therein, agrees:
- A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services
  - B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries, these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.
    - 1) In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as "Confidential Information."
    - 2) The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations."
  - C. To make available and, upon request, furnish all records described above within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, 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 transaction 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.
  - D. To accept assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid).
  - DE. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message.
  - EF. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the beneficiary or accept any additional payment from the beneficiary except cost share (co-pay or deductible amounts) established by the Medicaid Program.
  - FG. To take assignment and file claims with third party sources (medical or liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party source discovered after submission of a claim or claims to Medicaid.
  - GH. To make no charge to a beneficiary for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of a peer reviewer;

except that such charge may be made to the beneficiary when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined "not medically necessary."

**HI.** To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

**JI.** To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

**JK.** That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

**KL.** To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

**LM.** To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this certification as a matter of record for all claims submitted electronically, by any media.

**MN.** To notify the Department before any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered before the change in ownership or operating status.

**NO.** FOR HOSPITALS ONLY

To understand that the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospitals, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid covered services provided to eligible Medicaid beneficiaries in accordance with the applicable Medicaid reimbursement schedule in effect for the dates of service, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of applicable changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any medical records received by the Department or its fiscal intermediary, as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:

- 1) Returned mail
- 2) Death of provider
- 3) Change of ownership
- 4) Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

Provider Name: \_\_\_\_\_  
 (As inscribed on previous page of contract)

**Provider**

**Provider Enrollment**

By: \_\_\_\_\_  
 (Signature Required)

By: \_\_\_\_\_  
 (Signature)

Name: \_\_\_\_\_  
 (Typed or Printed Name Required)

Name: \_\_\_\_\_  
 (Typed Name)

Title: \_\_\_\_\_  
 (Required)

Title: \_\_\_\_\_

Date: \_\_\_\_\_  
 (Required)

Date: \_\_\_\_\_

Effective Date of Contract: \_\_\_\_\_

