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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Dear Applicant:

Thank you for your interest in becoming a provider under the Hawaii State Medical Assistance Program (Medicaid). The enclosed brochure summarizes the services covered under this program.

Please complete and sign the enclosed application. Failure to sign the application and provide the requested information may result in the application being returned without action.

Required Forms:

- ❑ **Part A (Medicaid Application/Change Request Form)**
- ❑ **Part B & C (Provider Agreement and Condition of Participation)**
- ❑ **Part E (Disclosure Information)**

Optional:

- ❑ **Part D (Early & Periodic Screening, Diagnosis, and Treatment Provider Agreement)** Applicable only to providers who provide regular medical or dental services to individuals under the age of 21.

Please submit a copy of the following with your application. Failure to provide the information below may result in a delay in the processing of your application:

- ❑ **National Provider Identifier (NPI) Notification (if applicable)**
- ❑ **Current Hawaii State License to practice in the State of Hawaii (Wallet Size or an issued letter from the Department of Consumer and Commerce Affairs)**
- ❑ **Board Specialty Certificate or Letter of Board Eligibility (if applicable). DO NOT SEND diplomas in lieu of Board Specialty Certification as these will not be accepted.**
- ❑ **Advance Practice Registered Nurse Specialty and/or American Nurses Credentialing Center Certification (if applicable). Medicaid eligibles are pediatric, family, certified nurse midwife, and behavioral health nurses. All other nurses, please refer to Appendix 1.**
- ❑ **IRS Form W-9 (Request for Taxpayer Identification Number and Certification)**

- ❑ **Drug Enforcement Administration Certificate of Registration for Controlled Substances (if applicable)**
- ❑ **Certificate from the State of Hawaii Department of Public Safety-Narcotics Enforcement Division (if applicable)**
- ❑ **Hawaii General Excise Tax License (if applicable)**
- ❑ **CLIA Certificate (certificate of accreditation for laboratory services if applicable)**
- ❑ **NCPDP Certificate (certificate of accreditation for pharmacy if applicable)**
- ❑ **CMS notification letter of provider's number from Medicare.**

Documents Not Required:

- Certificates of Insurance;
- Driver's License.

The following providers will also need to complete an additional form (refer to the MQD website at www.med-quest.us or call (808) 692-8099).

- ❍ Psychiatrist or Psychologist
- ❍ Non-emergency transportation (taxi-cab)
- ❍ EPSDT Case Management
- ❍ Home Health Agency
- ❍ Nursing Facility (ICF or SNF)
- ❍ ICF-MR Facility
- ❍ EPSDT Skilled Nursing/Personal Care
- ❍ Acute Hospital

The following providers are required to submit a copy of the current approved certificate from the Department of Health-Office of Health Care Assurance with their application:

- ❍ Ambulatory Surgical Center
- ❍ X-Ray Supplier
- ❍ Dialysis Center
- ❍ SNF / ICF Facility
- ❍ Laboratory
- ❍ Home Health Agency
- ❍ Acute Care Facility
- ❍ ICF-MR Facility

If your application is approved you will receive a letter from the Med-QUEST Division with your new Medicaid provider number. The Medicaid Provider Manual will be sent to you from the State's Medicaid fiscal agent, Affiliated Computer Services (ACS).

If you have questions regarding the application packet, please call our office at (808) 692-8099 or (808) 692-8094. Questions relating to claims processing should be directed to ACS at 952-5570 on Oahu or toll-free at 1-800-235-4378 (option 2).

NEW PROVIDERS HAWAII STATE MEDICAID PROGRAM

DHS 1139 (Rev. 04/08)

INSTRUCTIONS

PART A

Instructions for completing the
Hawaii State Medicaid Program Provider of Service Information Form (DHS 1139)
(www.med-quest.us)

NEW FEE-FOR-SERVICE (MEDICAID) or
QUALIFIED MEDICARE BENEFICIARY (QMB)

- ***Complete and provide ALL requested information LEGIBLY.***
- ***The application will be returned if requested information is not furnished.***
- ***Do not modify this form as this is a legal and binding contract***

Individual Application
If you are applying as a NEW sole proprietor or a NEW provider working for an established group, checkmark the *Individual* box located at the top of the DHS 1139 form.

Group Application
If you are applying as a NEW group provider or have a change in your Federal Tax Identification Number, checkmark the *Group* box at the top of the DHS 1139 form.

Medicaid Fee-For-Service Provider
An applicant, hereby after referred to as "*provider*", must circle "Y" for Medicaid Fee-For-Service Provider. Note: Claims from an approved Medicaid Fee-For-Service provider will automatically crossover to Medicaid from Medicare if the provider's Medicare number was submitted to Medicaid.

QMB - Only Provider
Circle "Y" for the "QMB-Only Provider," if the *provider* is registering as a QMB-Only Provider. Please refer to **Appendix 1** for definition.

Electronic Remittance
Circle "Y" for the "Electronic Remittance", if the provider wishes to receive electronic remittance advice rather than hard copy.

Medicaid Provider Manual
It is a requirement that a *provider* have at least one set of the Medicaid Provider Manual. Please circle "Y" for the "Electronic Provider Manual," if the *provider* wishes to receive the Medicaid Provider Manual on compact disk (CD) rather than hard copy paper form.

SECTION I - PROVIDER INFORMATION

Box	Field	Instructions
Box 1.	National Provider Identifier:	Enter the NPI number and include the enumerator letter with the application.
Box 2.	Provider Name:	Enter *provider's* Last Name, First Name and Middle Initial if the services will be rendered by an individual.
Box 3.	Provider's Registered Business Name / Doing Business As (d.b.a.) Name	Enter the applicable Provider's Registered Business Name or Doing Business As (d.b.a.) Name. Please check the appropriate box indicating the type of business venture. If "Other," please specify in the space provided.
Box 4.	Social Security Number:	Enter the *provider's* social security number. The use of this number is for verification purposes only.
Box 5.	Specialty Degree:	Provide a copy of the Board Certification or Board Letter for specialty(ies).
Box 6.	First Date of Service For Which a Claim Will Be Submitted:	Enter the *provider's* first date of service for which the *provider* will submit a claim to the State of Hawaii Medicaid Program. Failure to provide this information may result in claims being denied. This will be the same date as the effective date.

SECTION II - ADDRESS INFORMATION

Please indicate by checking the appropriate box. Note: A NEW State of Hawaii Medicaid Fee-For-Service *provider* is required to have at least one (1) correspondence address location, one (1) in-state service address location, and one (1) pay-to address location at the time of application.

Address Type	Instructions
CORRESPONDENCE ADDRESS:	This is the address to which all Medicaid correspondence for the *provider* will be mailed.
SERVICE ADDRESS:	1. This is the address at which the *provider* renders services. 2. All service locations must be identified. 3. For each service address, please indicate if the *provider* wishes to receive mail at the address in addition to receiving mail at the *provider's* correspondence address by checking "Y" or "N". 4. A Post Office Box CANNOT be used for a service address. 5. Rural service locations on the neighbor islands may add their physical location address on Street Line 1, and the Post Office Box on Street Line 2. 6. For additional location addresses, continue on Page 2 of the application form.
PAY-TO	1. This is the address to which payments for services rendered

ADDRESS:	by the *provider* are to be mailed. For additional location addresses may be using Page 2. 2. For each pay-to address, please indicate if the *provider* wishes to receive mail at the address in addition to receiving mail at the *provider's* correspondence address by checking "Y" or "N". 3. For additional location addresses, continue on Page 2 of the application form.

The following instructions may be used to complete the *provider's* correspondence, service, and pay-to addresses.

Box 7.	Attention To:	Enter the person or department to whom all inquiries or correspondence should be addressed at the given address, if applicable.
Box 8.	Street Line 1:	Enter the number and street address for the *provider*.
Box 9.	Street Line 2:	Enter additional address information for the *provider*, if necessary (i.e. suite, building, floor, or room number).
Box 10.	City, State/Zip/Code:	Enter the appropriate city associated with the *provider's* address information. Enter the appropriate 2-digit abbreviation identifying the state associated with the provider's address information. Enter the valid 5-digit code and 4-digit extension for the zip code associated with the *provider's* address.
Box 11.	Business Phone:	Enter the telephone number (including area code), to be used when contacting the *provider* during normal business hours.
Box 12.	Fax Number:	Enter the fax number (including area code), to be used when contacting the *provider* during normal business hours.
Box 13.	Begin Date:	Enter the effective begin date for the service and pay-to address. The effective dates for both addresses must be the same as in Box 6, Section I.
Box 14.	End Date:	Enter the effective end date for participation for the service and pay-to address when applicable.

Box 15.	CLIA Number:	If the service address location is for a laboratory <u>or</u> laboratory services will be performed at this service address location,

		enter the Clinical Laboratory Improvement Amendments (CLIA) Laboratory Certificate of Accreditation number. Attach a copy of the current CLIA certificate with this form.
Box 16.	NCPDP No.:	Enter the National Council for Prescription Drug Programs (NCPDP) certificate number if the service address is for a pharmacy. Attach a copy of the certificate with this form.
Box 17.	Federal Tax ID Number:	1. If the *provider* is a **sole proprietor**, indicate the applicable tax identification number (form 1099 reporting). 2. If the *provider* is working for a **Group**, fill in the Federal Employer Identification Number (FEIN) for the group. 3. If the *provider* is working for another individual provider or for themselves, the applicable SSN or FEIN of the other provider is required ***(the group or employing provider must be actively participating in the State of Hawaii Medicaid Program)***. 4. If the Group is not an established provider, a separate Group application must be submitted with at least one individual application denoting the individual's participation with the new Group. 5. A copy of the Form W-9, Request for Taxpayer Identification Number and Certification, must be attached to this form and the name listed on Form W-9 form must match the Pay-To Name exactly for the associated service address location. Failure to ensure that the Pay-To Name is reported correctly may result in claims being denied.
Box 18:	General Excise Tax Number:	1. If the *provider* is a sole proprietor, indicate the applicable tax identification number (for 1099 reporting). 2. If the *provider* is working for a Group, fill in the Hawaii General Excise Tax number for the group. 3. If the *provider* is working for another provider, enter the Hawaii General Excise Tax number of the other provider ***(the group or other provider must be actively participating in the State of Hawaii Medicaid Program).*** 4. Attach a copy of the General Excise Tax Certificate to this form; the name listed on the General Excise Tax Certificate must match the Pay-To Name exactly for the associated service address location. Failure to ensure that the Pay To Name is reported correctly may result in claims being denied.

SECTION III - ADDITIONAL INFORMATION

Box 19.	Hawaii State	Enter the appropriate identification number for the *provider's*

	License and Federal DEA Number:	license(s) or certification(s).Attach a current copy of all required licenses and certificates.
Box 20.	Licensing/ Certifying Agency:	Enter the name of the agency that issued the *provider's* license or certification, e.g., State of Hawaii Department of Commerce and Consumer Affairs (SOH/DCCA), Drug Enforcement Administration (DEA), etc.
Box 21.	Issue Date:	If indicated, enter the date the license or certification was originally issued by the agency (MM/DD/YYYY). *Note: The license or certification must cover dates of service the provider is requesting.*
Box 22.	Expiration Date:	If indicated, enter the date the license or certification expires (MM/DD/YYYY).
Box 23.	Agent Signature:	Individual(s) authorized to act as a signor on behalf of the *provider* for all Medicaid claims and claim correspondence must sign with their original signature. If additional lines are required, please attach a separate list. The provider must sign on Item ___ of this form and any additional list to indicate their approval. ***Note: The provider shall be the only person who can authorize and de-authorize an individual or individuals.***
Box 24.	Print Name:	Legibly print or type in the names of the individuals whose authorized signature appears in the Agent Signature field.
Box 25.	Begin Date:	Enter the appropriate date on which the authorized agent's signature will become effective.
Box 26.	End Date:	Not applicable if this is a new application. Enter the end date of participation with the Medicaid program.
Box 27.	Group Name:	Enter the group name (commercial bilker) authorized to bill on behalf of the *provider*, if applicable. Enter the group name which the individual provider will be affiliated with.
Box 28.	Association Begin Date:	Enter the date on which the *provider's* association with the group became effective which should match the effective date of the application.
Box 29.	Association End Date:	Enter the date on which the *provider's* association with the group terminates.
Box 30.	Medicare ID Number:	Enter the Medicare ID number assigned to the *provider* by Medicare listed on the CMS letter (attach a copy, if available).
Box 31.	**Provider Signature:**	• This application is not valid unless signed by the *provider.* • Original signature only. • Stamped signature not accepted. • Xerox copy of signature not accepted.
Box 32.	Date:	Enter the date the *provider* signed this application.

Box 33.	Provider Name:	Please type or print legibly the name of the individual whose signature appears in Box 31.

Filing Instructions for New Applicants & Updates to Provider Information:

Mail the form and all required documents to:

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Upon receipt of the Medicaid Application / Change Request Form (DHS 1139), the Health Coverage Management Branch will:

1. Review the form in its entirety and make a determination as to your request for participation in the State of Hawaii Medicaid Program.

2. If participation is approved, a welcome letter will be mailed to the *provider* by the State relaying the 6-digit Medicaid provider root number plus the 2-digit service locator code for each service location for claims to be filed. The approved effective date of participation, as determined by the State, will be also be stated.

3. Please be advised that all providers will eventually use their assigned 10-digit National Provider Identification (NPI) number. You will be notified by letter when the date to implement this change will take effect. Failure to comply with this mandatory action will result in non-payment of claims.

4. The NPI number will cover all service locations and claim forms must indicate this number on the claim.

Call the Health Coverage Management Branch at (808) 692-8099 or (808) 692-8094 -

- If there are questions regarding this form and its attachments;
- If additional copies of the form is needed; or If you wish to inquire on the status of your application

PARTS B AND C

Instructions for completing the
Agreement and Conditions of Participation

Purpose

This section outlines the agreement and conditions to participate in the Medicaid program as required by state and federal regulations.

Part B (Pages 5 – 6)

1. If you are an individual provider or will be employed with a group, circle 'I' and enter the name of the applicant.

2. If you are a group provider, circle 'We' and enter the name of the group or business that the application is being submitted for.

3. Paragraphs 1 – 10 states the agreements and conditions of participation for the Hawaii State Medicaid program. Please read through this section carefully.

Part C (Pages 6 – 8)

1. Retroactive Certification (1-year retro provision):
   a. The **original** signature is required by:
      i. the submitting applicant who will be providing services; **OR**
      ii. an authorized business agent (e.g., billing agent) who will be handling claims processing;

   b. Print *legibly.*

   c. Enter the date of the signature.

PART D

Instructions for completing the Early and Periodic Screening, Diagnosis, and Treatment Provider (EPSDT) Agreement

Purpose

To provide preventive, diagnostic, and screening services for children in accordance with Title 17,Chapter 1737 of the Hawaii Administrative Rules.

1. This agreement applies only to the following providers types who will be servicing EPSDT recipients:
   a. Internal Medicine;
   b. Dental;
   c. Family Medicine.

2. Full Signature of Provider:
   The original signature is required by the submitting applicant who will be providing services **OR** an authorized business agent (e.g., billing agent) who will be handling claims processing.
3. Print *legibly.*
4. Enter the date of the signature.
5. Effective Date Requested: enter the start date for participation in the Medicaid program.
6. *For DHS Official Use Only* – do not complete.

PART E

Instructions for completing the Disclosure Information Form

Purpose
The disclosure of this information to the Medicaid Agency **is a federal requirement.** The information must be furnished to the Medicaid Agency within 35 days of a written request per federal regulations (§455.104(3), §455.105(b), and §455.106). **The Department of Human Services (DHS) may refuse to enter into a contract and may suspend or terminate an existing agreement if the provider fails to disclose ownership or controlling information and related party transactions.**

1. Definitions are listed below to assist you in completing the form.

2. If there is no information to include, indicate **"None"** or **"Not applicable" (N/A)** in the space provided. Please do not leave sections blank. The application will be returned if this section is not filled in.

Information on Ownership and Control (Pages 10 – 12)

1. List the name, address, and title of the person(s) who has an ownership or controlling interest in your practice / company / or business (e.g. Individual - owner, partner or employee. Group - co-partner, president, vice-president). Ownership by another individual, company or business entity need not be listed.

2. List the name and address of the person(s) from your company who also has an ownership or controlling interest in any subcontractor (i.e., vendor) you utilize and which your company/business has direct or indirect ownership of 5 percent (5%) or more

3. List the names of any "Other Disclosing Entity" who has an ownership or controlling interest in your company/business and has ownership or a controlling interest in the "Other Disclosing Entity." The "Other Disclosing Entity" does not have to be a participating Medicaid provider; but does participate in other government programs such as Medicare. These "Other Disclosing Entity" may include a hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, or health maintenance organization that participates in Medicare.

Information Related to Business Transactions (Pages 11-12)

1. List the ownership of any subcontractor (i.e., vendors) with whom the disclosing entity has had business transactions totaling more than $25,000 during the past 12-month period.
   Optional unless requested at a later date: a printout of your Accounts Payable record that also indicates the mount paid (totaling more than $25,000).

   You may request the ownership information in writing from the individual or subcontractor and document their responses to you. You are required to advise the Medicaid Agency when there is no response from the individual or subcontractor to your request for this information.

2. List any significant business transactions during the past 5-year period:
   - between the disclosing entity and any wholly owned supplier; or
   - between the disclosing entity and any subcontractor.

3. The original signature is required by the submitting applicant who will be providing services **OR** an authorized business agent (e.g., billing agent) who will be handling claims processing;

4. Print *legibly*.

5. Enter the date of the signature.

DEFINITIONS FOR DISCLOSURE OF INFORMATION FORM

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

"Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

"Disclosing entity," means a Medicaid provider and/or Medicaid applicant.

"Fiscal agent" means a contractor that processes or pays vendor claims on behalf of the Department of Human Services.

"Indirect ownership interest" means an ownership interest in any 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.

"None" means no information to disclose.

"Not applicable" (N/A) means the same as "None".

"**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 (Maternal & Child Health Services), Title XVIII (Medicare), or Title XX (Grants to States for Social Services). This includes:

1) 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.

2) Any Medicare intermediary or carrier, and

3) Any entity 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 XIX (Medicaid) of the Social Security Act.

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

"Person with an ownership or controlling interest" means a person or corporation that:

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

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

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

4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (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?

"Significant business transaction" means any business transaction or series of transactions that, during one fiscal year exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

"Subcontractor" means:

1) 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

2) 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 DHS agreement.

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

"Wholly owned subsidiary supplier," means a subsidiary or supplier whose total ownership interest is held by the Medicaid provider/applicant or by a person, persons, or other entity with an ownership or controlling interest in the Medicaid provider/applicant.