PROVIDER ENROLLMENT FORM

BUSINESS INFORMATION

Company Name: _____ DBA (if applicable): _____

Address: _____ City/State/Zip: _____

Primary State of Operation: _____ Federal Tax ID: _____

Group NPI: _____ Medicaid # (if applicable): _____

Phone: _____ Fax: _____

Email: _____ Hours of Operation: _____

Provider Type / Discipline(s): ☐ ABA ☐ Speech (ST) ☐ Occupational Therapy (OT) ☐Other: _____

DISCLOSURE OF OWNERSHIP INFORMATION

WHY THIS INFORMATION IS REQUIRED

Owners and individuals with a direct or indirect ownership or controlling interest must provide personal identifying information, including date of birth, Social Security Number, home address, and ownership percentage. Federal and state enrollment rules for government healthcare programs require this disclosure. For Medicaid and other federal programs, the information is used to verify identity, disclose ownership and control interests, and complete the provider screening and federal database checks (such as OIG/LEIE exclusion and System for Award Management verification) mandated under the Social Security Act and its implementing regulations, including 42 C.F.R. §§ 455.104 and 455.434. All information is collected solely for credentialing and enrollment purposes and is handled confidentially in accordance with HIPAA and applicable privacy safeguards.

Owner #1: _____ Date of Birth (MM/DD/YYYY): _____

Home Address: _____ City/State/Zip: _____

Personal Phone: _____ Email: _____

% of Company Ownership: _____

Professional Certification / License(s) & Issuing State (if applicable): _____

1840 W 49TH ST STE 723, HIALEAH, FL 33012
TOLL-FREE PH: (888) 483-8044 | LOCAL PH: (786) 203-9259
PROVIDERSERVICES@HELPINGHANDSTC.COM

Owner #2: _____ Date of Birth (MM/DD/YYYY): _____

Home Address: _____ City/State/Zip: _____

Personal Phone: _____ Email: _____

% of Company Ownership: _____

Professional Certification / License(s) & Issuing State (if applicable): _____

Note: List any additional owners or individuals with 5% or more ownership or controlling interest on a separate attached sheet using the same fields above.

PREFERRED STATES & COUNTIES FOR ENROLLMENT

Preferred state(s) for enrollment / credentialing (list in order of priority):

Preferred counties / service areas:

Payor type(s) requested: ☐ Medicaid FFS ☐ Medicaid MCO ☐ Commercial ☐ TRICARE

Specific payors / networks requested (if known):

How will services be delivered? ☐ In person ☐ Telehealth ☐ Both

Population Served: ☐ Pediatric ☐ Adult ☐ Both

TELEHEALTH AND IN-STATE LOCATION REQUIREMENTS

Some Medicaid, managed care, commercial, and TRICARE health plans require a physical service location within the requested state to enroll or credential a provider, even when services will be delivered by telehealth

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only. Enrollment rules, telehealth policies, and location requirements differ by state, county, and payor and may change over time. Our team will review the applicable policies for each requested state, county, and payor and will advise you of any physical-location or other requirements before proceeding.

REQUIRED DOCUMENTS CHECKLIST

Document requirements vary by state, county, and payor. Please provide the commonly required items below; our team will confirm any additional documents needed for each requested state, county, and payor.

Business / Organization

- IRS EIN confirmation letter (CP-575 or 147C)
- Completed IRS Form W-9
- Professional / general liability insurance certificate (COI)
- Business license or entity formation document (if applicable)

Individual Provider (if enrolling individual practitioners)

- Government-issued photo ID
- Professional certification or diploma, such as BACB (BCBA/BCaBA) for ABA, ASHA CCC or state license for speech (ST), and NBCOT or state license for occupational therapy (OT)
- State professional license, where required
- Individual NPI (Type 1) confirmation (NPPES)
- Current resume or curriculum vitae (CV) with work history
- CAQH Number
- Social Security Number

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