



FACILITY

Below is a checklist for your convenience to ensure all required forms are completed in their entirety.

If any of the following items are not complete, do not have original signatures, are not dated, or if the items specified on the Type & Specialty page are not included, your entire application will be returned.

Note: As required by 42 CFR 455.434, the Centers for Medicare and Medicaid Services (CMS) regulatory guidance, and CMS sub-regulatory guidance, the Kansas Department for Health and Environment, Division of Health Care Finance (KDHE-DHCF) implemented Fingerprint-based Criminal Background Checks (FCBC) for "high" category of risk providers. High category of risk providers are newly enrolling Home Health Agency (HHA) and Durable Medical Equipment provider types.

Sign the application in BLUE ink. This helps minimize any confusion regarding original signatures. Copies of signed forms and/or stamped signatures are not acceptable. Unless otherwise noted, all requirements apply to individual applicants as well as group applicants.

- Application Information
Kansas Medical Assistance Program (KMAP) Provider Application
Facility/Business Provider Agreement
Provider Attestation
Billing Agent and Clearinghouse
Disclosure of Ownership and Control Interest Statement
KMAP Provider Agreement
Current license
W-9
Application fee, if applicable



Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

WELCOME TO KMAP

Thank you for your interest in the Kansas Medical Assistance Program (KMAP). All of the application materials within this document must be completed and returned to the fiscal agent for your enrollment to be processed. A checklist of required documentation has been provided for your convenience. Submission of incomplete application materials will delay your enrollment. In order to facilitate the assignment of a provider number, complete and submit the application materials with **ORIGINAL SIGNATURES**. Please retain copies of your application materials for your records. You will receive written notification upon approval or denial of your enrollment.

All claims must be received by the current fiscal agent within one year from the date of service. Claims not received in a timely manner (within one year from the date of service) will not be considered for reimbursement except for claims submitted to Medicare, claims determined to be payable by reason of appeal or court decision, or as a result of agency error.

Regulations regarding payment of services to out-of-state providers (more than 50 miles from the Kansas border) allow payment consideration for out-of-state services provided to KMAP beneficiaries if one of the following situations exists:

- An out-of-state provider may be reimbursed for covered services required on an emergency basis.
 - An emergency is defined as those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
 - In these situations, contact the KMAP Prior Authorization department to receive authorization prior to services being rendered. Failure to contact the Prior Authorization department may result in denial of your claim.
- An out-of-state provider may be reimbursed for nonemergency services if the Prior Authorization department, on behalf of the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), determines that the services are medically necessary.

Note: Failure to meet either of the above situations may result in denial of your claim.

If either situation presently exists or may exist, then complete the enclosed application forms and provide all of the requested information.

If you have questions concerning enrollment, contact Provider Enrollment.

- PO Box 3571, Topeka, Kansas 66601
- 1-800-933-6593, option 3 (between 8:00 a.m. and 5:00 p.m., Monday through Friday)



APPLICATION INFORMATION

Name _____ Title _____

Tax ID # _____ Social Security # _____

Date of birth _____ State _____

County _____ Group # _____

NPI # _____ CLIA # _____

Medicare # _____ Insurance _____
(Need effective and end date for standardized application)

Admit privileges _____ Provider type _____
(For MDs & DOs, need effective date) (Put appropriate number from Type & Specialty page)

Provider specialty(s) _____
(Put appropriate number from Type & Specialty page)

License information for practice/service address:

State _____ License # _____ Effective date _____ Expiration date _____

TYPE OF PRACTICE (check only one):
Corporation [] Government [] Hospital Physician [] Partnership [] Not for Profit []
Privately Owned [] Sole Proprietor [] Individual Practice []

For HP use only. Do not use.

CTMS _____ RECD DATE _____ PROVIDER # _____

New [] Duplicate [] Reactivation [] 18-month reactivation [] Revalidation [] App Fee []

Group Members _____

Sanction Information:
SAM (OIG) []
LEIE (OIG) []
SSDMF []
NEW WAVE []
NPPES []
License []

EFFECTIVE DATE _____
Provider request [] _____ Agreement date [] _____
DOS of claim [] _____ Admit date [] _____
License date [] _____ Medicare [] _____
CDDO date [] _____ Policy [] _____
State request [] _____ Insurance date [] _____
Other [] _____

HP Notes

Request date _____
Reason _____
State response _____



KMAP FACILITY PROVIDER APPLICATION

Choose one: [] New Enrollment [] Revalidation

This application must be completed in its entirety; do not leave any questions blank. If a question is not applicable, indicate so with an N/A in the appropriate field. Incomplete applications will result in a delay in the assignment of your KMAP provider number.

DATE []

PROVIDER'S NAME []

PROVIDER'S TAX IDENTIFICATION NUMBER []

The federal tax identification (ID) number given will be used for IRS tax reporting purposes. If this number changes at any time, you are required to notify this office in writing, and this may result in the assignment of a new KMAP billing provider number. If a federal tax ID number is listed, include a copy of your IRS notification. If you have an existing billing provider number and have had changes to your federal tax ID number, it is necessary to send a copy of the IRS notification.

PROVIDER'S LICENSE NUMBER []

LICENSE EFFECTIVE AND EXPIRATION DATES: FROM [] TO []

PROVIDER'S NPI NUMBER []

PROVIDER'S CLIA NUMBER []

CLIA EFFECTIVE AND EXPIRATION DATES: FROM [] TO []

The Clinical Laboratory Improvement Act (CLIA) of 1988 requires all providers at all locations performing laboratory testing, including office laboratories, to be registered with the CLIA program.

WAS THE PREVIOUS OWNER ENROLLED IN THE KMAP PROGRAM? YES [] NO []

PREVIOUS KMAP PROVIDER NAME AND NUMBER []

DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES []



Kansas Medical Assistance Program
 P O Box 3571
 Topeka, KS 66601-3571
 Provider 1-800-933-6593
 Beneficiary 1-800-766-9012

PROVIDER'S PHYSICAL LOCATION

STREET

CITY

STATE ZIP CODE
(Nine-digit code is required.)

PROVIDER'S BILLING ADDRESS/PAYEE

This is the address to which payments, remittance advices (RAs), and correspondence will be sent.

PAYEE NAME
(if different from provider)

STREET

CITY

STATE ZIP CODE
(Nine-digit code is required.)

PROVIDER'S TELEPHONE NUMBER

TYPE OF PRACTICE ORGANIZATION:

<input type="checkbox"/> Individual practice	<input type="checkbox"/> Municipal or state-owned	<input type="checkbox"/> Partnership
<input type="checkbox"/> Charitable	<input type="checkbox"/> Corporation	<input type="checkbox"/> LLC
<input type="checkbox"/> Privately owned	<input type="checkbox"/> Hospital-based physician	

PROVIDER'S KMAP PRIMARY SPECIALTY

SECONDARY SPECIALTY

PROVIDER'S MEDICARE SPECIALTY

SECONDARY SPECIALTY

KANSAS SCHOOL DISTRICT (physical location only)

EFFECTIVE DATE SERVICES WILL FIRST BE PROVIDED TO KMAP BENEFICIARIES AT THIS LOCATION

ARE YOU A PROPRIETOR, INVESTOR, PARTNER, SUPERINTENDENT, EXECUTIVE OFFICER, BUSINESS MANAGER, OR CONSULTANT OF ANY CLINICAL LAB, DIAGNOSTIC OR TESTING CENTER, HOSPITAL, SURGICAL CENTER, OR OTHER BUSINESS DEALING WITH THE PROVISION OF ANCILLARY HEALTH SERVICES, EQUIPMENT, OR SUPPLIES?

YES NO

**IF NO, CONTINUE ON TO THE KMAP FACILITY/BUSINESS PROVIDER AGREEMENT.
 IF YES, PROVIDE THE INFORMATION BELOW. ATTACH ADDITIONAL PAGES IF NEEDED.**



IF THE ANSWER TO THE PREVIOUS QUESTION IS YES, THIS PAGE MUST BE COMPLETED.

NAME OF ORGANIZATION
FEDERAL TAX ID NUMBER
TELEPHONE NUMBER
STREET ADDRESS ZIP CODE
CITY STATE
TYPE OF ORGANIZATION
SIZE OF ORGANIZATION
PERCENT OF BUSINESS OWNED/INVESTED BY PRACTITIONERS OR HOSPITALS
NATURE OF BUSINESS INTERESTS (such as owner, partner, investor)

CHECK EACH APPLICABLE SERVICE AND INDICATE THE NUMBER OF BEDS FOR EACH:

GENERAL (medical/surgical/obstetrical) NUMBER OF BEDS
PSYCHIATRIC NUMBER OF BEDS
ALCOHOL & DRUG NUMBER OF BEDS
EMERGENCY ROOM NUMBER OF BEDS
TUBERCULOSIS NUMBER OF BEDS
PHYSICAL REHABILITATION NUMBER OF BEDS
RESPIRATORY NUMBER OF BEDS

DO ANY DOMESTIC CORPORATIONS OWN 80% OF MORE OF THE PROVIDER'S ASSETS? (list all)

Two empty text boxes for listing domestic corporations.

DO ANY FOREIGN CORPORATIONS OWN 80% OF MORE OF THE PROVIDER'S ASSETS?

(list all and list their respective states of incorporation)

Two empty text boxes for listing foreign corporations.

GOVERNMENT OWNERSHIP YES [] NO []

CHAIN AFFILIATE YES [] NO []



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

NAME OF GOVERNMENT UNIT

WHO IS/ARE THE OWNER(S) OF THE PHYSICAL PLANT?

IF SOLE PROPRIETORSHIP, LIST THE NAME OF THE OWNER

IF PARTNERSHIP, LIST THE NAME(S) OF THE PARTNER(S)

IF CORPPORATION, GIVE THE NAME OF THE CORPORATION
(indicate if nonprofit corporation)

The following questions must be completed fully before the KMAP facility/business provider agreement becomes effective:

OWNER(S) AND ADDRESS(ES) OF PREMISES

STREET **CITY**

STATE **ZIP CODE**

OWNER(S) AND ADDRESS(ES) OF THE FACILITY/BUSINESS

STREET **CITY**

STATE **ZIP CODE**

LESSEE(S) AND/OR SUBLESSE(S) AND ADDRESS(ES) WHEN APPLICABLE

STREET **CITY**

STATE **ZIP CODE**

I HEREBY AGREE TO THE ABOVE:

SIGNATURE OF PROVIDER **DATE**

CONTACT PERSON FOR QUESTIONS PERTAINING TO THIS APPLICATION

NAME

PHONE NUMBER

RETURN TO:
PROVIDER ENROLLMENT DEPARTMENT
P.O. BOX 3571
TOPEKA, KS 66601-3571



TYPE & SPECIALTY - FACILITY

01 - HOSPITAL

A hospital license is required.

- 010 ACUTE CARE HOSPITAL
Please check here if you are a critical access hospital.
011 PSYCHIATRIC HOSPITAL
012 REHABILITATION HOSPITAL
017 TUBERCULOSIS HOSPITAL
018 STATE INSTITUTION I/DD
019 STATE MENTAL HOSPITAL HM
351 INDIAN HEALTH SERVICES HOSPITAL
400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required.
An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.

02 - AMBULATORY SURGICAL CENTER

- 020 AMBULATORY SURGICAL CENTER (ASC)
A current license is required.
400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certification of completion, documenting a score of 80% or greater, is required.

04 - REHABILITATION FACILITY

A hospital license is required. A CARF certification is also required if an OOS provider.

- 041 TBI REHABILITATION FACILITY
042 NON-CMHC PARTIAL HOSPITALIZATION

05 - HOME HEALTH AGENCY

- 050 HOME HEALTH AGENCY (HHA) - CERTIFIED
A current home health license is required.
051 SPECIALIZED HOME NURSING SERVICES
Required to be currently enrolled as an HHA with KMAP. Documentation regarding the equipment to be used to render the telehealth visits is required. KDHE-DHCF site visit approval is required.
059 INDEPENDENT LIVING COUNSELING
A current home health license is required.
400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certification of completion, documenting a score of 80% or greater, is required.
521 SPECIALIZED MEDICAL CARE - RN
A current home health license and NPI are required.
523 SPECIALIZED MEDICAL CARE - LPN
A current home health license and NPI are required.

05 - HOME HEALTH AGENCY (continued)

- 556 SPECIALIZED MEDICAL CARE/MEDICAL RESPITE-TECHNOLOGY ASSISTED (TA)
557 LONG-TERM COMMUNITY CARE ATTENDANT (AGENCY-DIRECTED) TA
HHA: The MST must be 18 years of age or older with a high school diploma or equivalent; must meet the HHA's qualifications; must reside outside of the beneficiary's home; and must complete training and pass certification as regulated under K.A.R. 28-39-165 or 28-51-100 by the State of Kansas licensing agency. An attached copy of a HHA license is required. An NPI is not required.
An HCBS application is required.
560 HEALTH MAINTENANCE MONITORING (TA) - LPN/RN
561 INTERMITTENT INTENSIVE MEDICAL CARE (TA) - RN
HHA: The provider must be an RN or LPN trained with the medical skills necessary to care for and meet the medical needs of TA beneficiaries. An attached copy of an HHA license is required. An NPI is required.
An HCBS application is required.

06 - HOSPICE

- 060 HOSPICE
400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.

07 - CAPITATION PROVIDER

- 071 MANAGED CARE ORGANIZATION (MCO)

08 - CLINIC

- 080 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
A current Public Health Service Note of Grant Award or Notice of Approval from the Department of Health and Human Services is required and a copy of the Cost Report if requested by KDHE-DHCF. Forward to KDHE-DHCF for approval.
081 RURAL HEALTH CLINIC (RHC)
Confirmation of Interim Reimbursement/Payment Rate from Medicare and a Medicare certification letter or Medicare EOMB are required. Forward to KDHE-DHCF for approval.
083 FAMILY PLANNING CLINIC
181 MATERNITY CENTER
An approval letter from KDHE is required.
183 EARLY CHILDHOOD INTERVENTION (ECI)
A copy of the approval letter from the Local Infant-Toddler Services Network is required.

TYPE & SPECIALTY - FACILITY

08 – CLINIC

(continued)

- ___ 400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.
- ___ 401 SBIRT FQHC/RHC
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.

11 – MENTAL HEALTH PROVIDER

- ___ 111 COMMUNITY MENTAL HEALTH CENTER (CMHC)
A CMHC license is required.
- ___ 113 RESIDENTIAL ALCOHOL AND DRUG ABUSE TREATMENT FACILITIES
A copy of the license from KDADS-AAPS at the facility level denoting the facility is approved for Intermediate (ASAM III.3 and/or III.5) and/or Reintegration (ASAM III.1) is required. Enrollment for a hospital-based residential program requires a letter of approval from KDADS-AAPS.
- ___ 122 AFFILIATE (NON-CMHC)
An Affiliation Agreement with a CMHC is required.
- ___ 123 CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE (SED) WAIVER
- ___ 124 CMHC PARTIAL HOSPITALIZATION
- ___ 176 ALCOHOL AND DRUG REHABILITATION
An attached copy of a current license is required.
- ___ 232 BEHAVIORAL MANAGEMENT/PRTF
A letter from the KDADS MH PRTF program manager stating the provider has met the qualifications or licensing requirements to deliver such services is required.
- ___ 400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.
- ___ 403 CONSULTATIVE CLINICAL AND THERAPEUTIC SERVICES (CCTS)
A copy of the license from the Kansas Behavioral Science Regulatory Board or equivalent documentation is required. A completed Behavioral Interventions Attestation form is required.
- ___ 404 INTENSIVE INDIVIDUAL SUPPORTS (IIS) SERVICES
A completed Behavioral Interventions Attestation form is required.

12 – LOCAL EDUCATION AGENCY

- ___ 120 LOCAL EDUCATION AGENCY (LEA)

13 – PUBLIC HEALTH AGENCY

- ___ 131 PUBLIC HEALTH OR WELFARE AGENCY AND CLINIC
A license is NOT required.
- ___ 181 HOSPITAL MATERNAL/INFANT CLINIC
A license is NOT required. An approval letter from KDHE-DHCF is required.
- ___ 400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certificate of completion, documenting a score of 80% or greater, is required.

21 – TARGETED CASE MANAGEMENT

- ___ 186 FAMILY SERVICE COORDINATION FOR ECI (Targeted Case Management)
A copy of the approval letter from the Local Infant-Toddler Services Network is required.
- ___ 233 COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (CDDO)
- ___ 238 AFFILIATE (NON-CDDO)
The Affiliation Agreement for TCM I/DD services is required.

30 – RENAL DIALYSIS CENTER

- ___ 300 RENAL DIALYSIS CENTER
- ___ 400 SCREENING, BRIEF INTERVENTION, AND REFERRAL FOR TREATMENT (SBIRT)
The completed SBIRT Attestation form is required. An SBIRT CEU and/or certification of completion, documenting a score of 80% or greater, is required.

31 – INDIAN HEALTH PHYSICIAN

- ___ 351 INDIAN HEALTH SERVICES
- ___ 402 SBIRT IHS
A completed SBIRT Attestation form is required. An SBIRT CEU and/or certification of completion, documenting a score of 80% or greater, is required.

53 – HEAD START FACILITY

- ___ 345 GENERAL PEDIATRICIAN
A Proof of Certification as a Head Start facility is required with a notice of a Financial Assistance Award given by the federal government to enroll.

42 – TEACHING INSTITUTION

- ___ 010 ACUTE CARE HOSPITAL
A hospital license is required.



FACILITY/BUSINESS PROVIDER AGREEMENT

The Provider hereby agrees to participate in the Kansas Medical Assistance Program (KMAP) as administered by Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF).

The Provider agrees to maintain standards for participation in KMAP as provided in all federal and state laws and regulations affecting and implementing said program. The Provider agrees to maintain a licensed status by the State Department of Health and Environment of Kansas in a category as appropriate for participation in the program. (Facilities located outside the State of Kansas agree to maintain a licensed status in the appropriate licensing agency having jurisdiction over the state in which said facilities maintain operations.)

The Provider agrees to maintain standards sufficient for it to be certified and to continue in such a certified status which is in compliance with all pertinent requirements of the provisions contained in Title XIX of the Social Security Act and the rules pursuant to said act by the Secretary of the United States Department of Health and Human Services.

The Provider agrees to comply with all court orders as entered by any court of competent jurisdiction which may affect the validity, implementation, or enforcement of any federal and state law or regulation affecting the administration of KMAP.

The Provider agrees to cooperate in a program of independent medical evaluation and audit of the patients in the facility to the extent required by the program in which the Provider participates.

The Provider agrees to submit billings for authorized care, services, and goods in accordance with the form, manner, and in the amount as is provided by the KDHE-DHCF rules and regulations, and subsequent amendments thereto, and agrees to provide care and services on the basis of being compensated therefore in accordance with the applicable statutes and regulations of Kansas. It is agreed that in the event the Provider should receive payment for care, services, benefits, and goods in an amount in excess of that permitted by KDHE-DHCF rules and regulations, that such excessive payments may be deducted from future payment otherwise payable to the Provider. However, at the option of KDHE-DHCF, recovery of such payment may be made otherwise. The Provider will not lose the right to administrative and judicial review.

The Provider agrees not to submit bills or otherwise attempt to collect payment from the beneficiary, relative of the beneficiary, the beneficiary's estate, or others for care, services, benefits, and goods provided for beneficiaries which are benefits reimbursable under KMAP in accordance with the laws, rules, and regulations of KDHE-DHCF. However, if payment is received from any source other than KDHE-DHCF, the Provider is to credit KDHE-DHCF for the amount.

The Provider agrees to provide at least 60 days prior notice in the event of cessation of business, election to no longer participate in this program, transfers ownership or operation of said business, to reduction in type of care to be provided by the Provider. The Provider agrees to provide KDHE-DHCF with a cost report within 90 days following the aforementioned occurrence.



FACILITY/BUSINESS PROVIDER AGREEMENT

The Provider agrees to provide acceptable assurance of compliance with the requirements of Title VI of the Civil Rights Act of 1964, and Section 504 of 1973, concerning nondiscrimination in federally assisted programs.

The Provider agrees to give full cooperation to KDHE-DHCF and its duly authorized agents in the administration of the program. Furthermore, the Provider agrees to maintain records as required by federal, state, and KDHE-DHCF rules and regulations and to provide access to such records as may be requested by KDHE-DHCF, its designee, or the Department of Health and Human Services.

The words “on file” or “signature on file” when placed on the KMAP claim refers to the Provider’s signature on this document.

The Provider is hereby informed that provider agreements are effective no earlier than the date all state/federal requirements are met. If all requirements are not met, the effective date on which the requirements are met or the date the Provider submits an acceptable plan of correction or waiver request will be the effective date.

The effective date of the new provider enrollment is the date the enrollment agreement is date stamped by KDHE-DHCF or designee or the date of the change of ownership or lease agreement whichever is most current.

Failure to submit a timely notification will result in the new owner assuming responsibility for any overpayment made to the previous owner(s) before the transfer.

If the Provider (new owner) claims any rights to assume any receivables of the previous owner as to any payment from or through KDHE-DHCF, then the Provider will cause copies of all documentation of any such purchase of rights to be attached to this Agreement. Failure to do so will be deemed a waiver of any such rights by the Provider as among the parties to this Agreement.

Existing provider agreements will be assigned to the new owners subject to the terms and conditions under which they were originally issued.



PROVIDER ATTESTATION

This letter of attestation is being provided on behalf of the following individual or business entity.

Individual/business name [text box]

Physical address [text box]

Telephone number [text box]

Contact person [text box]

Type of building for business

- Free-standing building
Storefront (a store or other establishment that has frontage on a street or thoroughfare)
Professional office building with multiple office suites
Other (please specify)

Business hours of operation [text box]

Type of services provided (such as medical, pharmaceutical, equipment/medical supplier, personal care) [text box]

Is the place of business closed for lunch and/or deliveries? Yes [checkbox] No [checkbox]

Is the place of business ADA accessible? Yes [checkbox] No [checkbox]

Is there a sign indicating the presence of the business clearly visible at the entrance? Yes [checkbox] No [checkbox]

The provider agrees to comply with all state and federal laws, regulation, and professional standards applicable to services and professional activities provided to KMAP beneficiaries.

Under penalty of perjury, I certify by my signature the information provided is accurate. I also certify I am a duly authorized representative of the individual or business entity named above.

Provider signature [text box]

Printed name [text box]

Title [text box]

Date [text box]



Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

BILLING AGENT AND CLEARINGHOUSE

Do you use a billing agent and/or clearinghouse for any Kansas Medicaid function? Yes No

If yes, provide the following information:

Billing agent (if applicable)

Entity name:

Entity address:

Direct contact name:

Direct contact number:

Direct contact email address:

Clearinghouse (if applicable)

Entity name:

Entity address:

Direct contact name:

Direct contact number:

Direct contact email address:



STATE OF KANSAS

Disclosure of Ownership and Control Interest Statement

The Kansas Medical Assistance Program (KMAP) is required to collect disclosure of ownership, control interest and management information from providers who participate in Medicaid or the Children's Health Insurance Program (CHIP) and the federal regulations set forth in 42 CFR Part § 455. Required information includes:

- 1) The identity of all owners and others with a control interest of 5% or greater as described in 42 CFR § 455.104;
- 2) The identity of managing employees, agents and others in a position of influence or authority as described in 42 CFR § 455.104
- 3) Certain business transactions as described in 42 CFR § 455.105; and
- 4) Criminal conviction information for the provider, owners, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN) as described in 42 CFR § 455.106.

Completion and submission of this Disclosure of Ownership and Control Interest Statement is a condition of participation in KMAP. The Disclosure of Ownership and Control Interest Statement must be submitted upon enrollment; upon executing a provider agreement/contract; upon request of the Medicaid agency during revalidation; and within 35 days after any change in ownership of the disclosing provider entity.

Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider agreement/contract, or termination of existing provider agreement/contract.

Fill in each section. Every field must be complete. If fields are blank or the form is unreadable (e.g. due to illegible handwriting), the form will be returned for corrections/completeness and not processed.

Instructions for Disclosure of Ownership and Control Interest Statement

If additional space is needed, please note on the form the answer is being continued, and attach a sheet referencing the question number being continued. (For example: Question 1 Ownership Information, continued). Please see Glossary for definitions of bolded terms.

Providing the SSN and TIN (as applicable) is required under 42 CFR § 455.104; Any Statement without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Question 1 - 2 Ownership Information:

List the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Control Interest. If the Owner is a corporation, the primary business address must be listed and every business location and P.O. Box address.

Question 3 Ownership in Other Providers & Entities:

Please identify all other providers or entities owned or controlled by the individual(s) or organization(s) identified in question 1. This information is to identify shared and interconnected ownership and control interests.

Question 4 Familial Relationships of All Owners:

Only group providers answer this question. Report whether any of the persons listed in Questions 1, 2, 5, and 6 are related to each other and identify the parties and their relationship.

Question 5 Business Transactions with any Subcontractor:

Identify all subcontractors the provider entity had business transactions with totaling more than \$25,000 during the preceding 12-month period.

Question 5a Subcontractor Ownership:

List the Ownership of all Subcontractors the provider entity had business transactions totaling more than \$25,000 within the last twelve (12) month period.

Question 6 Significant Business Transactions with any Wholly Owned Supplier or Subcontractor Information:

List any *Significant Business Transactions* between provider entity and any Wholly Owned Supplier or Subcontractor during the past 5 years.

Question 7 Managing Employees

List information for all managing employees such as general manager, business manager, president, vice-president, CEO, CFO, administrator, director, board of directors, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Question 8 Outstanding Debt

Provide information on family or household members of individuals listed in questions 1-7 who have outstanding debt with any state Medicaid program or any other Federal agency or program.

Questions 9-11 and 12a Criminal Convictions, Adverse Legal Actions, Sanctions, Exclusions, Debarment, and Terminations:

List your own criminal convictions, adverse legal actions, exclusions, sanctions, debarments, and terminations, ***and*** for any person who has an ownership or control interest, or is an agent or managing employee of the provider entity. List all offenses related to each person's or provider entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these programs.

Question 12 Participation in Medicaid or Medicare

List the provider entities or individuals who have participated, previously or currently, in KMAP, any other state's Medicaid program, or Medicare regardless of the timeframe.

Question 13 Provider Entity subject to Section 6032 of the Deficit Reduction Act

Provider entities receiving payments in any federal fiscal year (October 1 to September 30) of at least \$5 million from the KMAP and KanCare managed care organizations (MCOs) are subject to the provisions contained within Section 6032 of the Deficit Reduction Act of 2005 (Pub. L.109-171).

Question 14 Contact Person

This question is self-explanatory.

Question 15 Address for Location of Records

This question is self-explanatory.

STATE OF KANSAS

Disclosure of Ownership and Control Interest Statement

Name of Provider Entity/Individual		EIN/SSN	
Date of Birth (for individual)	NPI	Taxonomy	
Physical Address		City/State	Zip Code

Fiscal agents and all providers must answer each question except where noted. If more space is needed, provide the information on a separate piece of paper and attach to this document.

<p>1. Do you have an ownership or control interest in the provider/fiscal agent/managed care entity or in any subcontractor in which the provider/fiscal agent has direct or indirect ownership of five percent or more? If Yes, give their information below.</p> <p style="text-align: center; font-size: small;"><i>42 CFR 455.104(b)(1)(i); 42 CFR 455.104(b)(1)(ii); 42 CFR 455.104(b)(1)(iii)</i></p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
--	---

#	Name (individual or corporation)	Primary Address	Email Address	Date of Birth (for individual)	Social Security Number (for individual) or Tax Identification Number (for corporation)	% of ownership
1A.						
1B.						
1C.						
1D.						
1E.						

<p>2. Are any persons named in question #1 related to each other? If yes, give the name(s) of person(s) and relationship(s) such as spouse, parent, child, or sibling.</p> <p><i>NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.</i></p> <p style="text-align: center; font-size: small;"><i>42 CFR 455.104(b)(2)</i></p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
---	---

#	Name	Relationship

3. Does any person (individual or corporation) named in question #1 have an **ownership or control interest** in any other Medicaid provider or in any provider 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? If yes, give the name(s), address(es), and tax ID(s) of the Medicaid provider or provider entity.

NOTE: Designate association to each person listed in question #1 by using 1A, 1B, 1C, etc.

42 CFR 455.104(b)(3)

Yes
 No

#	Name	Address	Tax Identification Number

Question 4 answered by group providers only.

4. Are any provider members of the group related to the listed owners or those with an **ownership or control interest** listed in question #1?

NOTE: Designate relationship to each person listed in question #1 by using 1A, 1B, 1C, etc.

Yes
 No

#	Name	Relationship	Date of Birth	Social Security Number

5. Has the provider entity had business transactions with any **subcontractor** totaling more than \$25,000 during the preceding 12-month period? If yes, give the information below for each **subcontractor**.

42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)

Yes
 No

#	Name	Address	Date of Birth (if individual)	Social Security Number (if individual) or Tax Identification Number
5A.				
5B.				
5C.				
5D.				
5E.				

5a. Provide the following for all provider entities or persons with an **ownership or control interest** in each **subcontractor** named in question #5.

Note: Designate association to **subcontractor** listed above by using 5A, 5B, 5C, etc.

42 CFR 455.104(b)(1)(iii); 42 CFR 455.105(b)(1)

#	Name	Address	Date of Birth	Social Security Number or Tax Identification Number

6. Has the provider entity had any **significant business transactions** with any **wholly owned supplier** or with any **subcontractor** during the preceding five year period? If yes, give the information below for each **wholly owned supplier** or **subcontractor**.

Yes
No

42 CFR 455.105(b)(2)

Name	Address	Description of Business Transaction

7. Provide the following information on all **managing employees** of the provider entity.

NOTE: This question cannot be blank.

42 CFR 455.104(b)(4)

Name	Address	Date of Birth	Social Security Number
A.			
B.			
C.			
D.			
E.			

<p>8. Does any family or household members of <u>any</u> of the provider entities or individuals listed under any question in this Statement have any outstanding debt with any state Medicaid program or any other Federal agency or program? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.</p> <p><i>NOTE: Designate association to each person listed in this question by using 1A, 1B, 5A, 5B, etc.</i></p>						Yes <input type="checkbox"/> No <input type="checkbox"/>	
#	Name	Address	Date of Birth	Social Security Number	Program	Amount of Debt	

<p>9. Has the provider entity, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider 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? If yes, provide the following information below.</p> <p style="text-align: right;"><i>42 CFR 455.106(a)(2)</i></p>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name	Description	Date		

10. Have any of the provider entities or individuals listed under any question in this Statement had any of the following healthcare related adverse legal actions imposed by any state Medicaid program or any other Federal agency or program:

- Criminal Conviction
- Administrative Sanction
- Program Exclusion
- Suspension of Payment
- Civil Monetary Penalty
- Assessment
- Program Debarment
- Criminal Fine
- Restitution Order
- Pending Civil Judgment
- Pending Criminal Judgment
- Judgment Pending Under False Claims Act

If yes, provide the following information below and attach copy of the adverse legal action notification(s).

Yes
No

Name	Program	State	Action	Date

11. Have any of the provider entities or individuals listed under any question in this Statement had any of the following non- healthcare related adverse legal actions:

- Criminal Conviction
- Administrative Sanction
- Program Exclusion
- Suspension of payment
- Civil Monetary Penalty
- Assessment
- Program Debarment

If yes, provide the following information below and attach copy of the adverse legal action notification(s).

Yes
No

Name	Program	State	Action	Date

12. Have any of the provider entities or individuals listed under any question in this Statement ever previously participated or currently participate as a provider in Kansas Medicaid or any other states' Medicaid program or Medicare? If yes, provide the following information below.

Yes
No

Name	Program	State

12a. Have any of the provider entities or individuals in question #12 ever had their billing privileges revoked or had their participation in the program terminated for cause? If yes, provide the following information below.			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name	Program	State	Date

12b. Do any of the provider entities or individuals listed in question #12 have any outstanding debt with Kansas Medicaid or any other state's Medicaid program or Medicare? If yes, provide the following information below and attach documentation of the arrangements made to repay the debt.				Yes <input type="checkbox"/> No <input type="checkbox"/>
Name	Program	State	Amount of Debt	Date

13. Is the provider entity part of a provider entity that is subject to the provisions contained in Section 6032 of the Deficit Reduction Act? If yes, provide the following below.			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Provider or Provider Entity	Address of Provider or Provider Entity	Tax Identification Number of Provider or Provider Entity	

14. Provide the following information for the contact person for audit purposes.	
Name	Title
Phone Number	Email Address

15. Provide the address for the physical location of the records required under K.A.R. 30-5-59.

NOTE: P.O. Boxes and drop boxes are not acceptable.

Address	City/State	Zip Code

ANY DOCUMENTATION OR ANSWERS PROVIDED ON THIS APPLICATION, INCLUDING THE LACK OF DOCUMENTATION OR ANSWERS, MAY BE USED IN THE CONSIDERATION OF THIS APPLICATION FOR APPROVAL. THE STATE WILL ONLY CONSIDER APPROVAL OF APPLICANTS THAT IT DETERMINES TO HAVE MET THE FEDERAL, STATE AND AGENCY GUIDELINES FOR PROGRAM INTEGRITY AND PROVIDER ENROLLMENT.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR, WHERE THE PROVIDER ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY OF HEALTH AND HUMAN SERVICES AS APPROPRIATE.

Name of Application Preparer (Typed or Printed) _____

Name of Authorized Agent (Typed or Printed) _____

Signature of Authorized Agent _____

Title of Authorized Agent _____

Date _____

GLOSSARY

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing provider entity.

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 provider entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing provider entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing provider 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 provider entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing provider 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 provider 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.

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).

Group Providers: a provider who has members affiliated to them.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Indirect Ownership Interest: an ownership interest in a provider entity that has an ownership interest in the disclosing provider entity. This term includes an ownership interest in any provider entity that has an indirect ownership interest in the disclosing provider entity.

Individual Provider: a healthcare practitioner who is solely practicing or is a member of a group or facility and who is licensed or certified by the state in which he/she delivers services and is credentialed and/or enrolled as a Medicaid participating provider.

Managing Employee: 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 operations of an institution, organization, or agency. CMS requires the identification of officers and directors of a provider entity organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation such as president, vice-president, CEO, CFO and board of directors.

Other Disclosing Provider Entity: any other Medicaid disclosing provider entity and any provider 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, XV III, 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 XV III);
- (b) Any Medicare intermediary or carrier; and
- (c) Any provider 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.

Ownership or Control Interest: an individual or corporation that—

- (a) Has an ownership interest totaling 5 percent or more in a disclosing provider entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing provider entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing provider 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 provider entity;
- (e) Is an officer or director of a disclosing provider entity that is organized as a corporation; or
- (f) Is a partner in a disclosing provider entity that is organized as a partnership.

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing provider entity.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand (\$25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other provider entity with an ownership or control interest in the Provider Entity.



K A N S A S

Kansas Medical Assistance Program

Provider Agreement

1. Provider's Name	2. Physical Address (street, city, state & zip)
3. Pay-to Name (if different than information given in No. 1)	4. Pay-to Address (street, city, state & zip)

Terms and Requirements

1. Rules, Regulations, Policies

The provider agrees to participate in the Kansas Medical Assistance Program (KMAP) and to comply with all applicable requirements for participation as set forth in federal and state statutes and regulations, and Program policies, within the authorities of such statutes and regulations, of the Kansas State Medicaid Agency (SMA) as published in the KMAP Provider Manuals and Bulletins. The provider also agrees to comply with all state and federal laws and regulations applicable to services delivered and professional activities.

The provider agrees that the KMAP General Provider Manuals and the Provider Manuals specific to the program and services, Provider Manual revisions and Provider Bulletins are a part of this agreement and are wholly incorporated by reference. The provider agrees to read them promptly. The Manuals represent Medicaid program limitations and requirements that providers must follow to receive payment and to continue participation in the Medicaid program under K.A.R. 30-5-59(c)(1). The Manuals are in addition to the requirements of the Medicaid Provider Agreement and any other contracts such as managed care contracts and contracts with other insurance carriers. The fiscal agent for the KMAP has prepared the Manuals for the SMA, but the requirements and limitations in the Manuals are the official requirements and limitations of the relationship between providers and the SMA. Please use the Manuals whenever billing or communicating with the KMAP.

The Manuals make available to Medicaid providers informational and procedural material needed for the prompt and accurate filing of claims for services rendered to KMAP consumers. The Manuals are not a complete description of all aspects of KMAP. Should a conflict occur between Manual material and laws and regulations regarding the KMAP, the latter takes precedence.

From time to time, program policies will change. The SMA will notify the provider in the form of bulletins and revised Manual pages published on the KMAP Website, and upon publication of those revised Manual pages, the contract between providers and the SMA is amended. It is important that all revisions be placed in the appropriate section of the Manual and obsolete pages removed when applicable. You may wish to keep obsolete Manual pages to resolve coverage questions for previous time periods.

The Manuals represent the official policy and interpretations of regulations of the SMA in the administration of the KMAP. No provider may claim, in any judicial or administrative proceeding or hearing, that the SMA modified or interpreted the Manuals based simply on an oral conversation unless such interpretation or modification was reduced to writing and signed by the Secretary of the SMA. The fiscal agent for the KMAP has no authority to modify or interpret the Manuals.

(Note: The provider must read the General Provider Manuals and all other applicable Provider Manuals before providing services to beneficiaries. Providers must follow documentation standards contained in the manuals beginning on the first date of service.)

2. Ownership Disclosure

The provider agrees that all required ownership and operating information is fully and truthfully disclosed on the Disclosure of Ownership and Control Interest Statement which is included as part of the Provider Application.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or the U.S. Department of Health and Human Services (HHS) full and complete information about 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.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS full and complete information about 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.

The provider agrees to submit within thirty-five (35) days of the date on a request by the SMA or HHS a full and complete updated Disclosure of Ownership and Control Interest Statement.

3. Change of Ownership

The provider agrees to report and disclose all required changes in ownership and operating information and that any reported or unreported changes may affect the status of this provider agreement. The provider agrees to report such change of ownership to the fiscal agent for the KMAP within thirty-five (35) days. Changes of ownership or tax identification number terminate this agreement and the new owner or provider must reapply and submit an updated Disclosure of Ownership and Control Interest Statement.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

4. Enrollment

An individually enrolled provider agrees that each provider performing services (except those services performed under the personal direction of an enrolled provider) must be individually enrolled in the KMAP and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to Kansas Medical Assistance consumers by the non-enrolled provider will be denied or, if paid in error, recouped by KMAP.

5. Internal Revenue Service (IRS) Reporting

The provider agrees that the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS and that as a member of a group practice an individual provider, billing as an individual rather than as a member of a group, cannot use the FEIN of the group practice. The provider acknowledges that the KMAP will report income to the IRS using only the SSN or FEIN of the billing provider or payee and that no income will be reported using the SSN or FEIN of the performing provider.

6. License, Certification, Registration

The provider agrees to maintain required licensed, certified or registered status for all categories for which participation is sought.

7. Record Keeping and Retention

The provider agrees that standardized definitions, accounting, statistics and reporting practices which are widely accepted in the provider field shall be followed and that all records necessary to disclose fully the payments claimed and services rendered shall be accurately maintained in a manner which is retrievable for a period of five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. The provider agrees that this record keeping requirement is not a limit on the ability of the SMA to recoup overpayments; overpayments can be recouped beyond the five year limit.

8. Access to Records, Confidentiality and Routine Review

The provider agrees that routine reviews may be conducted by the Department of Health and Human Services, the SMA, or its designee of services rendered and payments claimed for KMAP consumers and that during such reviews the provider is required to furnish to the reviewers records and original radiographs and other diagnostic images which may be requested. If the required records are retained on machine readable media, a hard copy of the records must be made available when requested. The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto. Providers shall follow all applicable state and federal laws and regulations related to confidentiality.

9. Claims for Services Rendered

The provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to KMAP for payment. The provider agrees that the services listed on all claims are medically necessary for the health of the patient and are personally furnished by the provider or by the provider's employee under the provider's personal direction, the charges for such services are just, unpaid, and actually due according to federal and state statutes and regulations and Program policy, as announced in KMAP Provider Manuals and Bulletins and are not in excess of regular fees; the information provided on the claim is true, accurate and complete; and the words "on file" or "signature on file" when placed on the KMAP claim refers to the provider's signature on this document.

10. Timely Filing of Claims

The provider agrees that all claims must be received by the KMAP fiscal agent within twelve (12) months from the date the service was provided and that claims which are originally received within twelve (12) months from the date of service but are not resolved before the twelve (12) month limitation expires, may be corrected and resubmitted up to twenty-four (24) months from the date of service.

11. Payment

The provider agrees to accept as payment in full, subject to audit, the amount paid by the KMAP, with the exception of authorized co-payment and spenddown. The provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Program costs, payments may be pended or reduced and a payment plan as determined by the Secretary of the SMA will be developed within federal and state guidelines.

12. Billing the Consumer

The provider agrees that claims for covered services not submitted within twelve (12) months of the date of service, when the provider has knowledge of KMAP coverage, cannot be billed to the consumer and that claims which are timely filed and subsequently denied because of provider errors cannot be billed to the consumer if the provider fails to correct the errors and resubmit the claim. A provider may bill consumers for services not covered by KMAP if the provider notified the consumer of the non-coverage prior to the provision of services. The consumer must acknowledge the notification in writing.

13. Overpayment

The provider agrees that if it received payment for services or goods in an amount in excess of payment permitted by the KMAP that such overpayments may be deducted from future payments otherwise payable to the provider or the provider associated with the provider's tax identification number or service location. The provider acknowledges that such remedy is not the only or exclusive remedy available to the SMA and that collection of the overpayment begins after its right to Administrative Review has been exhausted.

If funds have been overpaid or disallowed, the provider shall, within thirty (30) days of discovery by the provider or notification by the SMA or its agent, repay or make arrangements to repay on other terms approved by the SMA to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a provider of medical services and legal action by the SMA to recover such funds, including the legal rate of interest.

14. Fraud

The provider agrees that payment of claims is from federal or state funds, or both, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable federal or state laws. The provider acknowledges that he/she is accountable for claim information submitted personally by them or by their authorized employee regardless of the media by which the provider submits claims. The provider acknowledges that the submission of a false claim, cost report, document or other false information, charging the recipient for covered services except for authorized spenddown and co-payment, and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable federal and state laws. Among such applicable laws is K.S.A. 21-3844 et.seq. and amendments thereto (the Kansas Medicaid Fraud Control Act).

15. Termination

The provider agrees that the SMA may terminate a provider's participation in the Kansas Medical Assistance Program for noncompliance with one or more terms of this provider agreement or applicable state and federal laws and regulations. Among such applicable regulations are K.A.R. 30-5-60 and 42 CFR § 455 et. seq.

Upon a change of ownership, the new provider must notify the SMA: (1) whether services provided to beneficiaries by the old provider will continue under the new ownership or whether the services will be transferred to another provider; and (2) where the old provider's records will be located.

16. Civil Rights and 504 Compliance Assurances

The provider understands that the SMA policy is to comply with the applicable nondiscrimination, equal opportunity and affirmative action provisions of various federal and state laws, regulations and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. The provider understands that this compliance policy covers employment policies, practices, services, benefit programs and activities. The provider understands that the SMA will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the basis of race, color, national origin, ancestry, religion, age, sex, disability or political affiliation.

The provider shall agree: (a) to observe the provisions of the Kansas Act Against Discrimination and to not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, disability unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisements for employees, to include the phrase, "equal opportunity employer/service provider," or a similar phrase to be approved by the Kansas Human Rights Commission; (c) if the provider fails to comply with the manner in which the provider reports to the commission in accordance with the provisions of K.S.A. 44-1031, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; (d) if the provider is found to have committed a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Human Rights Commission that has become final, the provider shall be deemed to have breached this agreement and it may be canceled, terminated or suspended, in whole or in part, by the SMA; and (e) the provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor.

The provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin. The provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations are at 45 Code of Federal Regulations, Part 80.)

The provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of disability. (Specific regulations found at 45 Code of Federal Regulations, Part 84.) The provider assures that all services will be provided in compliance with the provisions of the Americans With Disabilities Act of 1990, which prohibits discrimination on the basis of disability. (Specific regulations are at 29 Code of Federal Regulations, Part 1630.)

The provider assures that all services will be provided in compliance with the provisions of the Age Discrimination in Employment Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations are at 45 Code of Federal Regulations, Part 90.)

17. Professional Standards

The provider agrees to comply with all state and federal laws, regulations, and professional standards applicable to services and professional activities provided to KMAP consumers

18. Provider Agreement Term and Effective Date

This Provider Agreement shall be continuous and ongoing as long as the provider meets the requirements for participation in the KMAP including periodic reenrollment as required by the SMA. The provider agrees that this Provider Agreement is effective if all requirements for enrollment are met on the date of signing by the provider, or may be effective no more than twelve (12) months prior to the signing if a claim for covered services has been received by the KMAP fiscal agent. If all requirements are not met, the date on which such requirements are met shall be the effective date of this Provider Agreement.

19. Signature of Provider:

I certify by my signature, under penalty of perjury, that I am the individual named in Box 1, page 1, or I am duly authorized by the person listed in Box 1, page 1, to bind such person to the terms of this Provider Agreement and that I have read and understand the Provider Agreement and all applicable Provider Manuals and Bulletins.

Provider signature:

By: _____

Printed Name: _____

Title: _____

Date: _____

Acceptance by the Secretary of the State Medicaid Agency

By _____ Date _____
Manager, Kansas Medical Assistance Program Provider Enrollment

Provider Application Fee Update

Per CMS final rule 6028-F, state Medicaid programs must collect an application fee for new provider applications, re-enrollments (revalidations), and reactivations.

The following providers are exempt from the application fee:

- Individual providers, nonphysician practitioners, or groups
- Providers who are enrolled with Medicare
- Providers who paid the application fee to either Medicare or another state Medicaid plan
- Applicable provider types indicated in the matrix on the following page

The application fee for 2019 will be \$586. Payment must be made in the form of a check or money order to the State of Kansas – Medicaid. This amount will go into effect for any application received on and after January 1, 2019.

The enrollment fee must be paid for each provider type. The matrix on the following page indicates the application fee requirements by provider type.

Note: In order to waive the application fee, enrollment or payment with Medicare must be verified through PECOS by the fiscal agent.

If an application fee is required and the appropriate payment is not included or is not in an acceptable format, the paperwork will be returned to the provider requesting proper payment.

The application fee will not be refunded in the event the application or revalidation is denied.

KMAP

[Kansas Medical Assistance Program](#)

- [Bulletins](#)
- [Manuals](#)
- [Forms](#)

Customer Service

- 1-800-933-6593
- 7:30 a.m. - 5:30 p.m.
Monday - Friday

Provider Type	Owe an application fee?	
	Individual	Business
1 Hospital	NA	Yes
2 Ambulatory Surgical Center	NA	Yes
3 Custodial Care Facility	NA	Yes
4 Rehabilitation Facility	NA	Yes
5 Home Health Agency	NA	Yes
6 Hospice	NA	Yes
7 Capitation Provider	NA	No
8 Clinic Maternity/Early Childhood Intervention/Family Planning Clinic	NA	No
8 Clinic RHC/FQHC	NA	Yes
9 Advance Practice Nurse	No	No
10 Mid-level Practitioner	No	No
11 Mental Health Provider	No	Yes (business) No (group)
12 Local Education Agency	NA	Yes
13 Public Health Agency	NA	No
14 Podiatrist	No	No
15 Chiropractor	No	No
17 Therapist	No	No
18 Optometrist	No	No
19 Optician	No	No
20 Audiologist	No	No
21 Targeted Case Management	No	Yes
22 Hearing Aid Dealer	NA	Yes
23 Nutritionist	No	No
24 Pharmacy	NA	Yes
25 Durable Medical Equipment	NA	Yes
26 Transportation Provider	No	Yes
27 Dentist	No	No
28 Laboratory	NA	Yes
29 X-Ray Clinic	NA	Yes
30 Renal Dialysis Center	NA	Yes
31 Physician	No	No
42 Teaching Institution	NA	Yes
45 QMB	No	No
53 Head Start Facility	NA	Yes
54 Screening Providers	NA	Yes
55 Home Community Based Services	No	Yes
56 WORK	No	No (agency or nonagency)
70 Data Access Entity	No	No



Kansas Medical Assistance Program
PO Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

ELECTRONIC SUBMISSION

Submit Kansas Medical Assistance Program claims electronically.

Benefits to submitting claims electronically include:

- Claims adjudicate within minutes
- Cost savings in postage, paper, and ink
- Reduced time in claim preparation

Benefits to submitting electronic claims directly to the fiscal agent include:

- Submitters only need to contact **the fiscal agent** for submission problems; there are no intermediaries.
- Claim adjudication occurs within minutes when submitting fee-for-service (FFS) claims directly to **the fiscal agent**; intermediaries often transmit claims the next day.
- No fees are associated with submissions to **the fiscal agent**.

The fiscal agent offers two free solutions for electronic claims.

- **KMAP secure website** – Claims can be filed online using the secure website. Claim adjudication occurs within seconds and allows any mistakes on a claim to be corrected and resubmitted. Beneficiary eligibility, claim status, prior authorization, pricing, and pharmacy NCPDP services are also available. Use of the KMAP secure website does not require an EDI application or an authorization test.
- **Provider Electronic Solutions** – This batch billing software allows a batch of institutional or professional claims to be uploaded to the KMAP secure website. Claim adjudication occurs within hours. Beneficiary eligibility, claim status, prior authorization, and pharmacy NCPDP transactions can also be created. Use of batch billing software requires an EDI application and an authorization test.

Another electronic claims solution:

Third-party software – A provider can select a software that meets his or her needs. An EDI application and an authorization test are required before submitting claims for payment. The electronic claims clearinghouse (intermediary) must be authorized with the fiscal agent.

For any questions regarding electronic claims or authorization testing, contact the EDI Help Desk:

- **1-800-933-6593**
- LOC-KSXIX-EDIKMAP@groups.ext.hpe.com



Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

ELECTRONIC FUNDS TRANSFER (EFT)

The State of Kansas offers electronic deposit to providers who request this service. Electronic deposit provides the highest degree of certainty that payments will be delivered securely, without the delays that can occur with paper warrants.

To sign up for electronic deposit, an Authorization for Electronic Deposit of Vendor Payment form must be completed and returned to the Kansas Department of Health and Environment, Division of Health Care Finance.

To request a form be mailed or faxed, please call:

Customer Service

1-800-933-6593

If you have questions completing the form, please call:

Kansas Department of Health and Environment, Division of Health Care Finance

785-296-3981 (Ask for the Finance department.)