For Fiscal Agent Internal Use Only

Provider Name: _____

Doc Type: _____ Provider Type: _____ Provider Specialty: _____

Tax ID: _____ Social Security: _____

Provider Number: _____

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

PROVIDER APPLICATION

1a. Is this application a transfer of ownership: Yes___ No___ If yes, provide previous owners' seven digit provider # and tax id: Provider # Tax ID:	1b. Legal Name of Provider: 2. Provider Type

2A. Type of Business or Facility ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other (Specify)

3. Business Name, if Different from Above

4. Employer/Tax ID Number/Social Security Number

5. Office Telephone Number/Ext. 5a.Billing Phone # 6. Length of time at Practice address in New Jersey

7. Name, Birth Date, Social Security #s of any administrators, agents and employees in managing positions: (use separate sheet if necessary)
a)
b)
c)

8. **Service Location Address** (Do not use PO Box)

Street

City State County Zip

9. **Pay To Address** (for Checks/Remittance Advice)

Street

City State Zip

10. **Mail To Address** (for Newsletters/Correspondence)

Street

City State Zip

11. E-mail Address 12. Fax #

13. Indicate NJ Charity Care Provider _____Yes _____No (Questions 14-17 are for NJ acute care hospitals only)

14. **Charity Care Pay To Address** (Remittance Advice)

Street

City State Zip

15. Charity Care Telephone Number/Extension 16. Charity Care Fax #

17. Charity Care E-mail Address

18. Indicate legal status of your organization: Profit _____ Non-Profit_____ Private_____ Public_____
If other, please specify_____

19. List the specific service(s) for which you are requesting approval for reimbursement under the programs administered in whole or in part by the Division of Medical Assistance and Health Services

20. Do you operate from more than one location? _____Yes _____No. If yes, list name, service address and Medicaid Provider Number or Tax Id if applicable.

a. _____

b. _____

c. _____

Please attach additional sheet if necessary.

21. Is the applicant a member of a chain organization. Yes____ No ____ If yes, indicate name:_____

22. Are you required from the New Jersey Department of Health to receive a Certificate of Need under the Health Facilities Planning Act?
_____Yes _____ No. If yes, attach a copy of the Certificate of Need.

23. If your business or facility requires a current license/permit, indicate type _____ and number _____
Please attach a copy of the current license/permit, e.g., Independent Laboratory Certification.

24. CERTIFICATION, ACCREDITATION OR APPROVAL: Specify type and attach copy, for example, JCAHO (hospitals); New Jersey Department of Human Services (clinics); Division of Mental Health Services (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist).

25. Approved by Medicare? _____Yes _____No. If yes, what is your Medicare provider number _____, and also attach copy of your Medicare approval.

26. NPI number: _____

26A. Please report a bed count for your facility_____.

27. If Out-of-State Provider: Are you approved as a Medicaid provider in your State? _____ Yes _____ No. If yes, attach a copy of the approval letter from your state's Medicaid agency and your state's Medicaid Provider Number_____.

28. List the names, SSA Number, Date of Birth, License/Permit Number and Degree(s) for all professional staff in the organization, including but not limited to physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, lab directors, lab techs, etc. Also include those employees and agents directly involved with the delivery of Medicaid services and/or the processing of claims. If a hospital, you only need to provide senior management (example: CEO, CFO, administrators). If more space is needed, attach additional sheets.

	Name	SSA Number	Date of Birth	License/Permit Number	Degree, e.g., MD, DO, DDS, RPT, PhD, OD, RN, LPN
a.					
b.					
c.					
d.					
e.					

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

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

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

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

d. Ever been the subject of any past or pending suspensions, debarments, disqualifications or recovery action or criminal convictions involving Medicaid, Medicare, any other federally or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DMAHS? Yes ____ No ____. If yes, explain, and indicate current status of action:

e. Ever owned or had any financial interest in any other provider participating in the New Jersey Medicaid Program of any other state or jurisdiction? Yes ____ No ___. If Yes, list provider name and nature of relationship.

30. Do you charge for goods and/or services? TO ALL _____ or TO CERTAIN GROUPS ONLY _____.
If you charge to all or only certain groups, please explain your arrangement.
(Attach a copy of your fee schedule)

31. List days and hours of operation.

32. NOTE: There are federal and state statutes and regulations governing kickbacks and referral practices which may apply to the applicant and to those individuals and entities listed in this application. These statutes and regulations include, but are not limited to: The Federal Medicare and Medicaid Anti-Kickback Statute (42 USC 1320a-7b(b)); the Federal Safe Harbor Regulations (42 CFR 1001:952); the Stark Laws (42 USC 1395nn, 42 USC 1396b(s) and implementing regulations); the State Medicaid Anti-Kickback Statute (NJS 30:4D-17(c)); and the Codey Law (NJS 45:9-22.4 et. seq.) and its implementing regulations (NJAC 13:35-6.17)). Applicants should carefully review and understand these legal requirements and prohibitions, because signing this Agreement is a representation that there is full compliance with all these statutes and regulations.

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

Signature of Provider Representative | Print Name and Title | Date

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[ ] Approve [ ] Disapprove [ ] Other Initial_____ Date_____