



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL CARE PROGRAM**  
**PROVIDER APPLICATION**  
(Revision Date 5/16/11)

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at (410) 767-5340.

**NOTE: PLEASE ATTACH A COPY OF ALL REQUESTED DOCUMENTS**

**1) APPLICATION TYPE**

Check the appropriate box. If the request is to change existing data, then you must also include your Medicaid Provider Number. If you have already rendered service please indicate a Requested Enrollment Begin Date.

**2) PROVIDER INFORMATION**

If you have a business, such as pharmacy or medical supply, or a professional group, enter the company name or corporate group name. All physicians and other individual practitioners should enter last name, first name, middle initial and professional title.

Enter the address, telephone and fax number of your primary practice location, contact person name and their telephone number and the practice email or website address. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

Enter the appropriate two-digit code for county of your business or practice location address. A listing of the county codes is provided for your reference at the end of these instructions.

Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions. Applicants for the Kidney Disease Program (KDP) must also enter the two-digit KDP code.

Enter the Federal Employer ID Number, National Provider Identification (NPI) and the Social Security Number of the individual, group or business to whom the Medicaid reimbursements will be made.

**3) LICENSE/PERMIT INFORMATION**

Enter your professional license number, beginning effective date and expiration date for each practice location in which you service Maryland Medicaid recipients. If out of state, attach a copy of the current license certificate. Enter your NABP number if applicable.

Enter your Drug Enforcement Agency number and attach a copy of your DEA certificate. If you do not have a DEA number, this box should be left blank.

Enter your pharmacy permit number, if applicable.

Medical laboratory providers, practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** the following:

- Enter Clinical Laboratory Improvement Amendment (CLIA) #
- Attach a copy of CLIA Certificate
- Enter Maryland Laboratory Permit or Letter of Permit Exception #
- Attach copy of Maryland Laboratory Permit or Letter of Permit Exception

Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland.

Practitioners providing laboratory services to **OTHER THAN THEIR OWN PATIENTS** MUST enroll as medical laboratory providers.

**4) PRACTICE INFORMATION**

Enter the appropriate two-digit code for your type of practice. If this does not apply, leave blank. For your reference, a listing of the practice codes is provided at the end of these instructions.

**5) SPECIALTY INFORMATION**

Enter a "P" to designate the primary specialty. If multiple specialty codes are entered, then you must designate one specialty as the primary specialty.

Physicians, Dentists, and Pharmacies **MUST** enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Enter OTH if you have another specialty not listed. **PLEASE SPECIFY.**

Enter the date you were certified for your specialty in MMDDYY format.

Enter the number, up to six digits, that was provided to you when you were certified for the associated specialty.

**6) SPECIALTY VERIFICATION**

Please check the applicable statement and attach the required documentation.

**7) GROUP MEMBERSHIP INFORMATION**

If you are a **MEMBER OF A GROUP PRACTICE**, please enter the name, Maryland Medicaid provider number and the effective date you became a member of the group. If you are a **GROUP PRACTICE**, please list the names of each professional practicing in your group and his/her individual Maryland Medicaid provider number and membership effective date. All rendering practitioners in the group **MUST** individually be enrolled as a Maryland Medicaid provider.

**8) MEDICARE INFORMATION**

If you participate in Medicare, please list the fiscal intermediaries with whom you are enrolled (i.e. Blue Cross of Maryland, Traveler's Group Hospital Insurance, etc.) and enter the provider number each has assigned to you.

**9) ALTERNATE ADDRESS INFORMATION**

Enter the Pay-To-Address address, you want your Medicaid reimbursement checks mailed. If you leave this section blank, your checks will be mailed to the primary practice location entered on the first page of the application.

Enter the Correspondence Address you want all your Medicaid related correspondence and remittance advices mailed. If you leave this area blank, correspondence will be mailed to the primary practice location entered on the first page of the application. Also, please indicate if you would like to receive correspondence electronically. If yes, please include your email address on the first page of the application.

**10) OTHER PRACTICE LOCATION INFORMATION**

Please enter other locations where you serve Maryland Medicaid recipients. Include all group addresses where you are currently practicing. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

**11) MEDICAID INFORMATION: OTHER STATES**

Please indicate if you are a Medicaid provider in another state. Please indicate the state that you are a provider and indicate your number..

**12) AUTHORIZATION**

Please sign and date the application. No one can sign on your behalf.

**MEDICAL CARE PROGRAM -PROVIDER APPLICATION INSTRUCTIONS**

**PROVIDER TYPE CODES**

AC	Acupuncture- Children ONLY	51	EPSDT Therapeutic Intervention- Children ONLY	23	Nurse Practitioner (Indiv. Or Group)
50	ADAA Certified Addictions Outpatient Prog.	52	EPSDT Therapeutic Nursery	24	Nurse Psychotherapist (Indiv. Or Group)
T1	Ambulance Services	72	HealthChoice and PAC Managed Care Organizations	57	Nursing Facility
39	Ambulatory Surgical Center-Must be Medicare Certified			76	Older Adults Waiver Provider
		40	Home and Community Based Services- Autism Waiver	18	Occupational Therapist (Indiv. Or Group)- Children ONLY
AT	Attendant Care Waiver-Living at Home Waiver Provider	41	Home Health Agency- Must be Medicare Certified	63	Oxygen Services
19	Audiology Services Provider- Children ONLY	71	Hospice Provider- Must be Medicare Certified	MH	Partial Hospitalization Program (Mental Health)
		01	Hospital, Acute	44	Personal Care Aid
81	Case Management	03	Hospital, Rehabilitation Acute	45	Personal Care Aid Agency
CC	Certified Professional Counselor	04	Hospital, Rehabilitation Chronic	47	Personal Care Monitor
82	Children's Medical Services (CMS) Provider	05	Hospital, Chronic	RX	Pharmacy
13	Chiropractor- Children ONLY	06	Hospital, Special Pediatric	16	Physical Therapist (Indiv. Or Group)
30	Clinic, Abortion	07	Hospital, Special Psychiatric	20	Physician (Indiv. Or Group)
		55	Intermediate Care Facility-Addiction (ICF-A)- Children ONLY	11	Podiatrist (Indiv. Or Group)
32	Clinic, Drug Abuse (Methadone)			59	Portable X-Ray
				53	Private Duty Nursing-Must be Residential Service Agency
33	Clinic, Family Planning	10	Laboratories, Medical	15	Psychologist (Indiv. Or Group)
34	Clinic, Federally Qualified Health Center	91	Local Education Agencies/ Local Lead Agencies	PR	Psychiatric Rehab. Program
35	Clinic, Local Health Department	72	MCO (HealthChoice and PAC)	87	REM Case Management Providers
36	Clinic, Maryland Qualified Health Centers	42	Medical Day Care, Adult	88	Residential Service Center
		43	Medical Day Care, Children	89	Residential Treatment Waiver Services
38	Clinic, General	MA	Medicare Advantage Plan	92	Prescribing Providers- ONLY
83	Comprehensive Outpatient Rehabilitation Facility (CORF)	CM	Mental Health Case Management Provider	93	Senior Center Plus
90	DDA Services Provider	MC	Mental Health Clinic	94	Social Worker (Indiv. or Group)
14	Dental	27	Mental Health Group Provider (Psychotherapist, Social Worker, Nurse Psychotherapist)	17	Speech/Language Pathologist (Indiv. or Group)
60	Diagnostic Services, Other			95	State Agency
61	Dialysis Facilities	MT	Mobile Treatment (Mental Health)	28	Therapy Group Provider (PT. OT. Speech)
85	Dietician/Nutritionists- Children and Pregnant Women ONLY	21	Nurse Anesthetists (Indiv. Or Group)	86	Traumatic Brain Injury Waiver
62	DME/DMS- Must be Medicare Certified	22	Nurse Midwife (Indiv. Or Group)	08	Urgent Care Centers
				12	Vision Care

**KIDNEY DISEASE PROGRAM**

K1	Physician	K6	Hospital- Inpatient
K2	Pharmacy	K7	Medical Laboratory
K3	Dialysis Facility	K8	Other (dental, vision)
K5	Hospital-Outpatient		

**TYPE OF PRACTICE CODES**

35	Group Practice	99	Other
50	HMO	20	Pharmacy, single store
30	Individual Practice	21	Pharmacy chain, 2-10 stores
31	Individual Practice, L/P hospital only	22	Pharmacy chain, 11+ stores
32	Individual Practice, Emerg. Room only	23	Pharmacy, hospital based
33	Individual Practice, O/P or clinic only	24	Pharmacy, nursing home based
10	Nursing Home	25	Pharmacy, tax supported

**COUNTY CODES**

01	Allegany	07	Cecil	13	Howard	19	Somerset	40	Washington, DC
02	Anne Arundel	08	Charles	14	Kent	20	Talbot	99	Other State
03	Baltimore County	09	Dorchester	15	Montgomery	21	Washington		
04	Calvert	10	Frederick	16	Prince George's	22	Wicomico		
05	Caroline	11	Garrett	17	Queen Anne's	23	Worcester		
06	Carroll	12	Harford	18	St. Mary's	30	Baltimore City		

**SPECIALTY CODES**

**PHYSICIAN SPECIALTY CODES**

026	Allergy & Immunology	008	Gynecologic Oncology	019	Pediatric Critical Care Medicine
045	Anatomic & Clinical Pathology	035	Hematology	020	Pediatric Endocrinology
046	Anatomic Pathology	036	Infectious Disease	021	Pediatric Gastroenterology
041	Anesthesiology	030	Internal Medicine	022	Pediatric Hematology- Oncology
031	Cardiovascular Disease	009	Maternal & Fetal Medicine	023	Pediatric Nephrology
053	Child & Adolescent Psychiatry	037	Medical Oncology	024	Pediatric Pulmonology
047	Clinical Pathology	025	Neonatal- Perinatal Medicine	002	Pediatric Surgery
004	Colon& Rectal Surgery	038	Nephrology	016	Pediatric
032	Critical Care Medicine	014	Neurological Surgery	048	Physical Medicine & Rehabilitation
060	Dermatological Immunology/ Diagnostic & Laboratory Immunology	050	Neurology	011	Plastic Surgery
058	Dermatology	051	Neurology with Special Qualification in Child Neurology	052	Psychiatry
059	Dermatopathology	044	Nuclear Medicine	049	Public Health & General Preventive Medicine
017	Diagnostic Lab Immunology	057	Nuclear Radiology	039	Pulmonary Disease
055	Diagnostic Radiology	007	Obstetrics & Gynecology	056	Radiation Oncology
043	Emergency Medicine	015	Ophthalmology	054	Radiology
033	Endocrinology & Metabolism	013	Orthopedic Surgery	010	Reproductive Endocrinology
029	Family Practice	183	Osteopath	040	Rheumatology
034	Gastroenterology	012	Otolaryngology	001	Surgery
028	General Practice	186	Pathology	005	Thoracic Surgery
003	General Vascular Surgery	018	Pediatric Cardiology	006	Urology

**DENTAL SPECIALTY CODES**

113	Dental- Other	181	Oral Surgery
123	Endodontics	182	Orthodontics
057	Nuclear Radiology	187	Pedodontics
131	General Dentistry	188	Periodontics

**PHARMACY SPECIALTY CODES**

147	Home IV Therapy	184	Other Pharmacy
151	Hospital Outpatient Pharmacy	202	Retail Chain Pharmacy
156	Institutional Pharmacy	204	Retail Single Pharmacy
168	Multi-Specialty Pharmacy		

**MEDICAL CARE PROGRAM—PROVIDER APPLICATION**

**IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION**

**1) APPLICATION TYPE:**

NPI: \_\_\_\_\_

New Enrollment

Re-Enrollment

Existing Provider/ InformationChange

Provider Number: \_\_\_\_\_

I am applying as a..... Please check one:

Requested Enrollment Begin Date \_\_\_\_\_

Group of Practitioners

Individual Practitioner- Solo Practitioner or Member of a Group (Please circle type)

Facility/ Institution/ Business/ Agency (Please circle type)

**2) PROVIDER INFORMATION**

\*Please refer to the instructions for the appropriate codes.

Group/Facility/ Business/ Agency Name: \_\_\_\_\_

Physician/Practitioner Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Primary Practice Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Handicap Access: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax : \_\_\_\_\_ County Code: \_\_\_\_\_ Provider Type Code: \_\_\_\_\_

Employer Identification Number: \_\_\_\_\_ Name of EIN Owner: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Medicare Provider Number: \_\_\_\_\_ Fiscal Year End Date: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

**3) LICENSE/PERMIT INFORMATION**

**License/ Permit Type**

**Individual:**

**Professional:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

**DEA:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

Good Standing: Yes: No:

**Institutional:**

**MDLAB:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

**CLIA:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

**NABP:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

**Pharmacy:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

**NCPDP:** State Issued:\_\_\_\_ License/Permit Number:\_\_\_\_\_ Date Issued:\_\_\_\_\_ Expiration Date:\_\_\_\_\_

Good Standing: Yes: No:

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**4) PRACTICE INFORMATION**

**\*Please refer to instructions for appropriate codes.**

Type of Practice: \_\_\_\_\_

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**5) SPECIALTY INFORMATION (IF APPLICABLE)**

**\*Please refer to the instructions for appropriate codes.**

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Primary / Secondary Specialty: \_\_\_\_\_ Specialty Code: \_\_\_\_\_

Certification Date: \_\_\_\_\_ Certification Number: \_\_\_\_\_

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**6) SPECIALTY VERIFICATION**

Please check the applicable statement and attach the required documentation. Pursuant to the Physicians Services Regulations (COMAR 10.09.02), the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the following criteria:

I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.

I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.

I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.

I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty board that I am board eligible is attached.

I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

If your application is for a group or professional association, each physician/practitioner in the group or association who wishes to be considered a specialist must submit the required verification.

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**7) GROUP MEMBERSHIP INFORMATION**

Group Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_

Group Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_

Group Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_

Group Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_

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**8) MEDICARE INFORMATION**

Name: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Name: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Name: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

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**9) ALTERNATIVE ADDRESS INFORMATION****Pay To Address:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Correspondence Address:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available?**Yes: \_\_\_\_\_ No: \_\_\_\_\_

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**10) OTHER PRACTICE LOCATION INFORMATION**

Please enter other locations where you provide healthcare services for Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. \*Please refer to the instructions for appropriate codes.

**Practice Address #2**

Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Handicap Access: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Country Code: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Practice Address #3**

Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Handicap Access: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Country Code: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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**11) MEDICAID INFORMATION**

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Name: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
State: \_\_\_\_\_

Name: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
State: \_\_\_\_\_

Name: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
State: \_\_\_\_\_

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**12) AUTHORIZATION**

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

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

Type or Print Name of Practitioner, Administrator or  
Authorized Professional Responsible for the Quality of Patient Care: \_\_\_\_\_

Signature of Practitioner, Administrator or  
Authorized Professional Responsible for the Quality of Patient Care: \_\_\_\_\_

Signature of Owner (in the case of a Pharmacy): \_\_\_\_\_

Please Return Completed Application to:      Systems and Operations Administration,  
Provider Enrollment  
P.O. Box 17030  
Baltimore, MD 21203

**PROVIDER APPLICATION PRACTITIONER AND GROUP ADDENDUM**

**PRACTITIONER**

If you are participating in a group practice, do you also provide care to Maryland Medicaid recipients in your private practice and wish to be reimbursed directly by the State (your personal tax identification number must appear on this application)?

Yes:                      No:

**GROUP**

If your group is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group’s duties:

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Is your group salaried by the above institution?      Yes:      No:

If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)?      Yes:      No:

If you are an O. D., are you practicing optometry exclusively? Yes:      No:      or optometry as well as preparing and dispensing eyeglasses (as an optician)?      Yes:      No:

Is your group operating a Local Health Department Clinic?      Yes:      No:

Is your group operating a Freestanding Clinic?      Yes:      No:

**NOTE: All practitioners in a group must be enrolled as Medical Care Program rendering providers.**

**LABORATORY INFORMATION**

**Completion of this section is required by individual practitioners and groups.** Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients?      Yes:      No:

Do you provide medical laboratory services for other than your own patients?      Yes:      No:

Do you receive specimens that are obtained from other sites located in Maryland?      Yes:      No:

All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

**INSTITUTIONAL BED DATA:**

Nursing Facility (NF) Number of Beds: \_\_\_\_\_ Chronic Hospital (CHB) Number of Beds: \_\_\_\_\_

Acute Inpatient (INP) Number of Beds: \_\_\_\_\_ Intellectual Disability (ID) Number of Beds: \_\_\_\_\_

Other (OTH) Number of Beds: \_\_\_\_\_



**PROVIDER OWNERSHIP AND DISCLOSURE FORM**  
**(Applicable to all Providers of items or services<sup>1</sup> except for individual practitioners or groups of practitioners<sup>2</sup>)**

Provider Name : \_\_\_\_\_

Provider Address: \_\_\_\_\_

Pursuant to 42 CFR 455.100 et seq., the disclosure of the following is a required portion of the Maryland Medicaid Provider Application. Therefore, please answer the following questions and sign this document affirming that this information is true and complete, and return with your application.

A. Name any person, who, with respect to the Title XIX Provider<sup>3</sup>

1. is an officer or director:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

2. is a partner:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

3. has direct or indirect ownership interest<sup>4</sup> of 5% or more:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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<sup>1</sup> "Provider" or "provider" of services means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

<sup>2</sup> "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) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

<sup>3</sup> Identify any persons named, who are related to others named, as spouse, parent, child or sibling.

<sup>4</sup> a). "Ownership interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

b) "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

c) "Determination of ownership or control percentage"

1) Indirect ownership interest- The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing 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 entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) 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 the disclosing 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.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

4. has a combination of direct or indirect ownership interests equal to 5% or more in the Provider

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

5. is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

B. With respect to any subcontractor in which the Title XIX Provider has, directly or indirectly, an ownership or control interest of 5% or more, name any person who falls within Part A. 1-5 above, as applied to the subcontractor and specify which of the above categories he falls within

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

- C. 1. If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with 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, XVII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship.

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling

Relationship: \_\_\_\_\_

- D. Name any person who has been convicted<sup>5</sup> of a criminal offense related to his involvement with any program operated under Title XVIII, XIX, or XX of the Social Security Act, and who, with regard to the Title XIX Provider, falls within the provisions of A.1-5, above, or is an agent or a managing employee [an individual, including a general manager, administrator and director, who exercises operational or managerial control or who directly or indirectly conducts the day-to-day operations]

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

- A. the ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and
- B. any significant business transactions<sup>6</sup>, occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier<sup>7</sup> or any subcontractor.

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

POSITION: \_\_\_\_\_

<sup>5</sup> "Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, irrespective of whether an appeal from that judgment is pending.

<sup>6</sup> "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5 percent of the total operating expense of a provider.

<sup>7</sup> "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).

