

Provider Inputs

03/29/2016

Input Forms PS-I-001 Provider Application Form

General Information

CMS Center for Medicare and Medicaid Services regulations became effective November 1, 2001. In order to capture the new data elements for the VaMMIS system design, the Provider Application Form (PS-S-0010) had to be developed. The Provider Application Form is completed by providers when they apply for eligibility. This application describes the provisions and conditions with which the provider must comply in order to participate in the State's Medicaid and Non-Medicaid programs.

Subsystem:	Provider
Source/Originator:	Provider
Frequency:	Daily
Estimated Volume:	200 per week
Programs:	N/A
Proc/Screen ID:	None

Provider Application Form (PS-I-001)



For First Health's Use Only

Tracking Number _____

Provider Number _____

Base ID _____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

- 1. PROVIDER PROGRAM: ___ Medicaid ___ Medallion ___ Medallion II ___ State and Local Hospital (SLH)
 ___ Client Medical Management (CMM)
 ___ Temporary Detention Order (TDO)
 ___ Family Access to Medical Insurance Security Plan (FAMIS)

2. REQUESTED EFFECTIVE DATE OF ENROLLMENT _____

3. EXISTING VIRGINIA MEDICAID PROVIDER NUMBERS _____

4. LEGAL BUSINESS NAME: _____
 (if applicable, as registered with the Internal Revenue Service)

OR

INDIVIDUAL NAME: _____ SUFFIX _____ TITLE _____
 (Name of the provider who performs the service)

5. LICENSE/CERTIFICATION NUMBER _____ LICENSING BOARD _____
 ISSUING STATE AND ENTITY _____

6. PRIMARY SPECIALTY _____ LICENSING BOARD _____
 SECONDARY SPECIALTY _____ LICENSING BOARD _____

7. FDA MAMMOGRAPHY CERTIFICATION NUMBER _____

8. UPIN (UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER) _____

9. DEA (DRUG ENFORCEMENT AGENCY) NUMBER FOR THIS LOCATION _____

REMARKS:

Provider Application Form (PS-I-001)

10. IRS NAME _____

11. SOCIAL SECURITY NUMBER _____ EFFECTIVE DATE _____ END DATE _____

12. EMPLOYER TAX ID NUMBER _____ EFFECTIVE DATE _____ END DATE _____

13. TYPE OF APPLICANT (Please check one)

- Individual Corporation Hospital Based Physician Sole Proprietorship
 Group Partnership Health Maintenance Organization (HMO)
 Limited Liability Partner

14. FACILITY RATING (Please check one)

- Profit Non-Profit Not Applicable

15. FACILITY CONTROL (Please check one)

- State Private Public
 City Charity Not Applicable

16. FISCAL YEAR END

Month _____ Begin Date _____ End Date _____

17. ADMINISTRATOR'S NAME _____

18. NUMBER OF BEDS

- NF SNF-NF SNF
 ICF-MR Non-Cert Specialized Care

19. CLIA NUMBER _____

SIGNATURE _____ DATE _____

REMARKS:

Field Definitions

#	Field Name	Data Element Name	Element ID
1	Provider Program		DE0000
3	Existing Virginia Medicaid Numbers	Provider Carrier Code	DE4222
5	License/Certification Number	Provider License Number	DE4064
6	Licensing Board		DE0000
7	Primary Specialty	Provider Specialty Code	DE4007
8	Secondary Specialty		DE0000
9	FDA Mammography Certification Number		DE0000
11	DEA		DE0000
14	Facility Rating		DE0000
15	Type of Applicant	Provider Type	DE4006
16	Facility Control	Provider Type of Practice Organization	DE4009
17	Fiscal Year End		DE0000
18	Administrator's Name	Provider Contact Name	DE4201
19	Number of Beds		DE0000
20	CLIA Number	Clinical Laboratory Improvement Amendment (CLIA) Number	DE4310
21	Servicing Address Attention	Provider Attention Name	DE4096
22	Servicing Address	Provider Address Line	DE4097
23	Servicing Address City	Provider Address City Name	DE4130
24	Servicing Address State	Provider Address State	DE4098
25	Servicing Address ZIP Code	Provider Address ZIP Code	DE4099
26	Servicing Address Office Phone	Provider Phone Number	DE4090
27	Servicing Address Office Phone EXT		DE0000
28	Servicing Address 24 hour Phone		DE0000
28	Servicing Address TDD Phone		DE0000
29	Servicing Address FAX Number		DE0000
30	Servicing Address E-mail Address		DE0000
31	Servicing Address Contact Name		DE0000
32	Servicing Address Contact Phone		DE0000
33	Correspondence Address Attention		DE0000
34	Correspondence Address: Address		DE0000
35	Correspondence Address City		DE0000
36	Correspondence Address: Street		DE0000
37	Correspondence Address Room/Suite		DE0000
38	Correspondence Address City		DE0000

39	Correspondence Address ZIP		DE0000
40	Correspondence Address State		DE0000
41	Pay To Address: Attention	Provider Name	DE4085
42	Pay To Address: Address	Provider Address Line	DE4097
43	Pay To Address: City	Provider Address City Name	DE4130
44	Pay To Address State	Provider Address State	DE4098
45	Pay To Address State	Provider Address State	DE4098
46	Pay To Address ZIP	Provider Address ZIP Code	DE4099
47	Pay To Address Office Phone		DE0000
48	Pay To Address: EXT		DE0000
49	Pay To Address: E-mail Address		DE0000
50	Pay To Address: 24 Hour Phone		DE0000
51	Pay To Address: TDD Phone		DE0000
52	Pay To Address: FAX Number		DE0000
53	Pay To Address: E-mail Address		DE0000
54	Pay To Address: Contact Name		DE0000
55	Remittance Advice Address: Attention		DE0000
56	Remittance Advice Address: Address		DE0000
57	Remittance Advice Address: Street		DE0000
58	Remittance Advice Address: Room/Suite		DE0000
59	Remittance Advice Address: City		DE0000
60	Remittance Advice Address: State		DE0000
61	Remittance Advice Address: ZIP		DE0000
62	Remittance Advice Address: Office Phone		DE0000
63	Remittance Advice Address: EXT		DE0000
64	Remittance Advice Address: 24 hour phone		DE0000
65	Remittance Advice Address: TDD Phone		DE0000
66	Remittance Advice Address: FAX Number		DE0000
67	Remittance Advice Address: E-mail Address		DE0000
68	Remittance Advice Address: Contact Name		DE0000
69	Remittance Advice Address: Contact Phone		DE0000

