CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING CASE MANAGEMENT PROVIDER

A participating elderly case management provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed agreement with DMAS. (See “Exhibits” at the end of the chapter for a sample of this form.)

CASE MANAGEMENT AGENCIES

Case management agencies provide services designed to prevent or reduce inappropriate institutional care by providing the continuous assessment, coordination, and monitoring of needs and services for Medicaid-eligible individuals who:

- Are age 60 and over;
- Are screened through one of the Case Management agencies and found dependent in two or more of the following activities of daily living: bathing, dressing, eating, toileting or continence;
- Reside in one of the following project areas:
  - Area 1: Fairfax County, Fairfax City and Falls Church;
  - Area 2: Lee, Scott, Wise, Russell, Buchanan, Dickenson, Tazewell, Smyth, Wythe, Bland, Carroll, Grayson, Montgomery, Floyd, Pulaski, Giles Counties and Radford and Galax Cities.
  - Area 3: Rappahannock, Lancaster, Northumberland, Richmond, Westmoreland, Essex, Gloucester, King William, Mathews, Middlesex, Isle of Wight, Southampton, Accomac, Northampton Counties and Norfolk, Virginia Beach, Portsmouth, Chesapeake, Franklin, Suffolk, Newport News, Williamsburg and Hampton Cities; and
- Are in need of case management services.

The following provisions govern providers of case management services.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients. The provider must request the participation agreement(s) by writing, telephoning, or faxing their requests to:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

1-(804) 270-5105 Toll free in state only - 1-(888) 829-5373
FAX (804) 270-7027

Requests will be screened to determine whether the applicant meets the basic requirements for participation (i.e., employing case managers who possess the knowledge, skills and abilities spelled out in this chapter).

An application for elderly case management provider status and information regarding the provider participation requirements and standards will be mailed to any interested party who requests information or an application to become a Medicaid-approved provider for elderly case management and who meets the basic requirements for participation. (See "Exhibits" at the end of the chapter for a sample of this form.)

Upon FIRST HEALTH receipt, review, and determination that the provider meets all the requirements for Medicaid case management provider participation, FIRST HEALTH will send the provider a copy of the agreement for review and signature. The agreement must have the original signature of the provider or person authorized to bind the provider under agreement.

PROVIDER IDENTIFICATION NUMBER

Upon the receipt of the signed agreement, and the approval and signature by DMAS, a provider identification number will be assigned. The provider will be sent a copy of the agreement and the assigned provider identification number. **DMAS will not reimburse the provider for any elderly case management services rendered prior to the assignment of this provider identification number.** This number must be used on all billing invoices and correspondence submitted to DMAS.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he

or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

PROVIDER PARTICIPATION STANDARDS

To be approved for case management agreements with DMAS, the following must be met:

- Staffing requirements;
- Financial solvency;
- Business office;
- Disclosure of ownership; and
- Assurance of the comparability of services

Agreements for the Elderly Case Management Program will remain in effect for one year unless cancelled earlier by the provider or by DMAS.

GENERAL REQUIREMENTS

Each provider approved for participation in the Medical Assistance Program as an elderly case management services provider must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS, in writing, of any changes in the level of care authorized and the individualized service plan which the facility previously submitted to DMAS;
- Ensure freedom of choice to recipients seeking medical care from any institution, pharmacy, practitioner, or other facility that is qualified to perform the required service(s) and participating in the Medicaid Program at the time the service(s) are performed;
- Ensure the recipient's freedom to reject medical care and treatment;
- Accept referrals for services only when staff is available to deliver the required services;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide to recipients services and supplies of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept DMAS payment from the first day of the recipient's eligibility;

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or recipients for broken or missed appointments.

  Example: If a third party payer reimburses $5 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Use Program-designated billing forms for submission of charges;

- Comply with the record maintenance and retention requirements:

  a. The facility agrees to maintain and keep adequate and verifiable information and records as are necessary to:

     i) Identify and disclose the extent of services, as identified on the Uniform Assessment Instrument (UAI) that the facility furnishes to recipients;

ii) Comply with the disclosure requirements of Subpart B of Title 42 of the Code of Federal Regulations (42 CFR §§ 455 et seq.);
iii) Ensure proper payment by DMAS;
iv) Receive payments under the Medicaid Program;
v) Satisfy and secure overpayments made under the Medicaid Program; and
vi) Survive any termination of the provider participation agreement;

b. The facility agrees to furnish the information required to be maintained to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested. This right of access to facilities and records shall survive any termination of the provider participation agreement;

c. In general, records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is longer. However if, an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every adjustment, retraction, exception, and appeal is resolved; and

d. In the event a facility discontinues operation, DMAS shall be notified in writing of the location and procedures for obtaining stored records for review. The location, agent, or trustee must be located within the Commonwealth of Virginia;

- Disclose all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

- Hold confidential and use for authorized DMAS purposes only all medical and identifying information regarding recipients served. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public;

- Employ and supervise professionally trained staff (meeting the requirements stated in this chapter) to provide case management services;

- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency; and

- Have operated as a care coordination provider prior to application for Medicaid case management provider status.

ADHERENCE TO PROVIDER AGREEMENT AND SPECIAL PARTICIPATION CONDITIONS

In addition to the above, all providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreement. The paragraphs which follow outline special participation conditions which must be agreed to by case management providers.

Recipient Choice of Provider Agencies

If case management services are authorized and there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of his or her choice.

Case Manager Requirements

The provider agency must employ and **directly supervise** an individual or individuals who will provide ongoing monitoring, re-evaluation, and coordination of services for all Elderly Case Management Program recipients who receive case management through the agency. To qualify as a provider of services for case management for the elderly through DMAS, case managers must meet the following qualifications. These qualifications must be available for DMAS review if requested or during utilization review.

The case manager must possess a combination of work experience or relevant education, which indicates that the individual possesses the following knowledge, skills, and abilities. The case manager must have these knowledge, skills, and abilities at the entry level which must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

A. Knowledge of:

1. Aging and the impact of disabilities and illnesses on aging;

2. Conducting client assessments (including psycho-social, health, and functional factors) and knowledge of their uses in care planning;

3. Interviewing techniques;

4. Consumers' rights;

5. Local human and health service delivery systems, including support services and public benefits eligibility requirements;

6. The principles of human behavior and interpersonal relationships;

7. Effective oral, written, and interpersonal communication principles and techniques;

8. General principles of record documentation; and

9. Service planning process and the major components of a service plan.

B. Skills in:

1. Negotiating with consumers and service providers;

2. Observing, recording, and reporting behaviors;

3. Identifying and documenting a consumer's needs for resources, services, and other assistance;

4. Identifying services within the established services system to meet the consumer's needs;

5. Coordinating the provision of services by diverse public and private providers; and

6. Analyzing and planning for the service needs of elderly persons;

C. Abilities to:

1. Demonstrate a positive regard for consumers and their families;

2. Be persistent and remain objective;

3. Work as a team member, maintaining effective inter- and intra-agency working relationships;

4. Work independently, performing position duties under general supervision;

5. Communicate effectively, orally, and in writing.

6. Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and

7. Interview.

Individuals meeting all of the above qualifications will be considered a qualified case manager. A minimum of an undergraduate degree in a human services field or a licensed nurse is preferred, as well as two years of satisfactory experience in the human services field working with the elderly.

Documentation of all staffs members' credentials shall be maintained in the provider agency's personnel file for review by DMAS staff.

The case manager's caseload should not exceed a number of recipients deemed desirable for optimum monitoring and re-evaluation ability. However, it is recognized that the abilities of the case manager to manage a caseload will depend on many variables (e.g., other duties, the availability of resources, the stage of disease process for the recipients in the caseload, etc). Caseload size will be judged by the review of the quality of plans of care and follow-up documentation of services to implement the plan of care for case management services.

Any agency, which meets DMAS requirements, may apply for an agreement with DMAS to provide case management services. This includes agencies located outside the program's geographic areas. However, payment will be made only for qualified recipients residing within the approved areas. Any agency applying to be a case management provider which also renders any other direct Medicaid-covered services must be able to clearly demonstrate that case management services will be provided by staff which have no participation in the delivery of direct services and that recipient freedom of choice and the ability to objectively monitor service delivery can be maintained.

Continuity of Service Provision

The case management provider is responsible for providing reliable, continuous monitoring and coordination of services to any Medicaid case management recipient. Any time the provider is unable to render care to a recipient, the recipient must be notified and allowed to decide whether to transfer to another case management provider.

Change of Ownership

When ownership of the provider agency changes, DMAS must be notified within 15 calendar days. A new agreement, notice of the organizational structure, statements of financial solvency and service comparability, as well as full disclosure of all information required by this chapter relating to ownership and interest, are required.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FH-PEU thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

In addition, a copy of the letter must be sent to:

DMAS/Waiver Services Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Subsection (c) of § 32.1-325 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action including termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process consists of three phases: a written response and reconsideration to the preliminary findings, an informal conference, and a formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request an informal conference, a formal evidentiary hearing, or both.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia) (the APA) and the *State Plan for Medical Assistanc*e provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA

EXHIBITS

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HOME AND COMMUNITY-BASED CARE APPLICATION for PROVIDER STATUS as a ELDERLY CASE MANAGEMENT PROVIDER

PART A. PREVIOUS PROVIDER EXPERIENCE

1. Type of Related Experience:

I request to be approved as a provider of Elderly Case Management services.
My agency is currently a Virginia Medicaid-enrolled provider of Home Health, Hospital, Rehab, Hospice, Nursing Facility, Clinic or one of the Community-Based Care services.

Yes ☐ **No** ☐

Type of Provider ____________________ Provider ID # ____________________

Type of Provider ____________________ Provider ID # ____________________

Type of Provider ____________________ Provider ID # ____________________

2. Has the agency delivered healthcare services for at least one year prior to the date of application?

Yes ☐ **No** ☐

If "yes" complete the following information.

____________________ ____________________ ____________________
Type of business Federal tax number First date of service delivery

If the answers to 1 and 2 are "yes", skip to part B, general information, otherwise go to 3.

3. ***If the answer to 2 is "No",*** has the administrator who will be on-site and ultimately responsible for daily operation of the agency, management of staff, programs and finances had at least one year's experience of prior healthcare delivery in an administrative position?

Yes ☐ **No** ☐

If "yes" answer the following, and complete the action noted below.

____________________ ____________________
Administrator's Name Name of agency at which experience was gained

____________________ ____________________
Dates employed in this capacity Type of business

List major job responsibilities ____________________

____

Action: If the answer to 3 is "Yes", indicate three references. These must attest to your level of competency in administering services and at least one must be from a professional familiar with the quality of services provided by the agency which employed you.

Name	Telephone Number	Occupation
1.		
2.		
3.		

If the answers to 2 and 3 are "No", you are not eligible to be considered for provider status at this time.

PART B. GENERAL INFORMATION

In accordance with Federal requirements, all providers of Home and Community-Based Care services must submit the following information to the Department of Medical Assistance Services. The information you provide in this section will help us identify information you send to us, and direct where we send critical information you will need as a provider. Please be sure you follow the directions and accurately note the information requested so that we can provide you with quality service.

ADMINISTRATIVE PERSONNEL ***(Fill in all that apply.)***

______________________ ______________________ ______________________
Person responsible for signing contract Title Phone number
- ☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:______________________________

______________________ ______________________ ______________________
Chief Administrator On-site Title Phone number
- ☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:______________________________

______________________ ______________________ ______________________
Other On-site Contact Person Title Phone number
- ☐ This person is responsible for general management of requested Medicaid program(s)

Reports to:______________________________

______________________ ______________________ ______________________
Chief Corporate Officer Title Phone number

______________________ ______________________ ______________________
Other Corporate Contact Person Title Phone number

GEOGRAPHICAL AREAS TO BE SERVED **(*See Chapter II for policy re: allowable service area)***

List Cities/Counties in which you intend to serve Medicaid-eligible recipients.

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

OWNERSHIP (FILL IN COMPLETELY FOR ALL OWNERS. INCLUDE PERCENT OF OWNERSHIP OF EACH)

LEGAL NAME	ADDRESS	%

OWNER(S) PARTICIPATION IN OTHER FEDERALLY FUNDED PROGRAMS
Federal requirements stipulate that any person listed above in with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVII, or XX of the Social Security Act must disclose such ownership.

CHECK ONE: _____ N/A _____ APPLICABLE, COMPLETE THIS SECTION

NAME	AGENCY NAME	TYPE OF BUSINESS

TYPE OF AGENCY (PLEASE CHECK ALL THAT APPLY)

Non-Profit
____ Church Related
____ Non-Profit Corporation
____ Other Non-Profit Ownership

Proprietary
____ Single Proprietorship
____ Partnership
____ Corporation
____ Hospital/Nursing Facility

State or Local Government
____ State
____ County/City
____ Hospital (District Authority)

CHECK ANY OF THE FOLLOWING SERVICES YOUR AGENCY PROVIDES:

- ☐ Durable Medical Equipment
- ☐ Rehabilitation Services
- ☐ Home Health
- ☐ Case Management
- ☐ Social Work Services
- ☐ Others ____________________
- ☐ Hospice

REQUIREMENTS AND SIGNATURE

Any changes which affect the accuracy of the information on this application must be reported promptly to the Waiver Services Unit of the Department of Medical Assistance Services.

Federal requirements stipulate that upon each submission of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal offense (misdemeanor and/or felony) must be made. It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.
Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense? **Yes** ☐ **No** ☐.
If yes, explain the type of offense, name and title of individual:____________________

____

The signature below certifies the following:

- That the chief administrative agent understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community-Based Care Services than is charged the private sector for the same services
- That there is neither a judgment nor pending action of insolvency or bankruptcy in a State or Federal Court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services.
- That the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community-Based Care services prior to completing this application.
- That the information within this application is accurate, truthful, and complete.
- That DMAS is authorized to make any contact or inquiries necessary to facilitate completion of the application process.

____________________ ____________________
Print Name of person signing application Print title

____________________ ____________________
Signature of person signing contract Date

PART C. CBC PROGRAM STAFF CREDENTIALS AND REQUIREMENTS

COMPLETE FOR ELDERLY CASE MANAGEMENT

You are responsible for assuring that all Case Management staff meet the qualifications detailed in chapter II of the provider manual. All case management staff are expected to be knowledgeable of the program criteria and requirements, regardless of whether they perform these activities on a part time basis. It is the provider's responsibility to assure that any new case management staff are oriented to the program and have the policy, procedures and forms necessary to comply with DMAS requirements.

List the Case Manager(s), educational background and experience in the delivery of Case Management Services:

Name:________________________________ Type of Degree/major course of study:______________________________
Describe knowledge of and/or experience with Infectious Disease (specifically HIV), Terminal Illness, developing assessments & care plans, monitoring need and receipt of services, accessing services____

____

Who does the Case Manager report to and list that person's program responsibilities:_____________________________________

____

List any other responsibilities Case Manager has:____

Does Case Manager participate in provision, authorization or oversight of any direct services? ☐ **Yes** ☐ **No**

Name:________________________________ Type of Degree/major course of study:______________________________
Describe knowledge of and/or experience with Infectious Disease (specifically HIV), Terminal Illness, developing assessments & care plans, monitoring need and receipt of services, accessing services:____

____

Who does the Case Manager report to and list that person's program responsibilities:_____________________________________

____

List any other responsibilities Case Manager has:____

Does Case Manager participate in provision, authorization or oversight of any direct services? ☐ **Yes** ☐ **No**

Name:________________________________ Type of Degree/major course of study:______________________________
Describe knowledge of and/or experience with Infectious Disease (specifically HIV), Terminal Illness, developing assessments & care plans, monitoring need and receipt of services, accessing services:_____________________________________

____

Who does the Case Manager report to and list that person's program responsibilities:_____________________________________

____

List any other responsibilities Case Manager has:____

Does Case Manager participate in provision, authorization or oversight of any direct services? ☐ **Yes** ☐ **No**

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Elderly Case Management

If re-enrolling, enter Medicaid Provider Number here→ ______________________ Check this box if requesting new number→ ☐

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this ________ day of ______________________________, ____________ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid**.**

1. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in provision of services**
2. **Services billed must be those provided by a case manager. Payment is to be made to those providers who actually render the services. Upon accepting a Medicaid recipient as a patient, the provider agrees to supply all items and services for the recipient in the same quality and mode of delivery which the provider supplies to the general public.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services and supplies will not exceed the usual, customary, and reasonable charges to the general public and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP at its established rates for services covered constitutes full payment on behalf of the recipient. The provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation of other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as the administrative policies and procedures of VMAP as from time to time amended.**
9. **The provider agrees to assure freedom of choice to recipients seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and who is participating in the Medicaid program at the time the service is performed. The provider assures the resident's freedom to reject medical care and treatment.**
10. **This agreement may be terminated at will on sixty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
12. **This agreement shall commence on ______________________. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health Services' use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

Title

_____City or _____County of

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: ______________________________

Provider Name: ____________________________________

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: ____________________________________

Date: ____________________________________

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803