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CHAPTER II
PROVIDER PARTICIPATION REQUIREMENTS

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CHAPTER II PROVIDER PARTICIPATION REQUIREMENTS

PARTICIPATING PROVIDER

A participating provider is a mental health clinic which has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

PROVIDER ENROLLMENT

Each provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. All providers must sign a Medicaid Provider Agreement. The signature must be an original signature. An agreement for specific psychiatric services must be signed by the authorized agent of the provider. All providers must complete the participation agreement and return it to the Provider Enrollment and Certification unit of FIRST HEALTH (FH/PEU).

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

DMAS is informing the provider community that NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

SPECIFIC PROVIDER REQUIREMENTS

Federal law requires that each clinic be physician-directed.

“As stipulated by section 1905 (a)(9) of title XIX of the Social Security Act, this requirement does not mean that the physician must necessarily be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all the hours that services are provided. However, each patient’s care must be under the supervision of a physician directly affiliated with the clinic. To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his/her patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically appropriate. Thus, physicians who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to

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the clinic’s patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement.”

The requirement for physician supervision of all patient care in the clinic is a condition of participation in Medicaid as a mental health clinic. The patient care protocols for treatment of Medicaid recipients must reflect the role of the physician, and the patient’s medical records must document that the physician has ordered the plan of care and is periodically reviewing the need for continued care. This requirement must be met for all clinic services billed to Medicaid by any employee of the mental health clinic.

Provider Qualifications for Psychiatric and Substance Abuse Services

Psychiatric Services may be provided by:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Virginia Board of Counseling; or
- A psychiatric clinical nurse specialist (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A psychiatric nurse practitioner, licensed by the Board of Nursing;
- A marriage and family therapist licensed by the Virginia Board of Counseling;
- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

Substance Abuse Services

In addition to the following licensure requirements, substance abuse treatment providers must also be qualified by training and experience in all of the following areas of substance abuse/addiction counseling: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; professional and ethical responsibilities.

Licensure Requirements:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry ;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;

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- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling; or
- A psychiatric clinical nurse specialist - Psychiatric (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A marriage and family therapist/counselor licensed by the Virginia Board of Counseling;
- An individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling;
- A psychiatric nurse practitioner, licensed by the Board of Nursing; or
- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under Virginia state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

Direct Supervision

When services are provided by an unlicensed individual, the provider must ensure that:

- The plan of care is approved and signed by the licensed professional. It must state the need for psychiatric treatment; the objectives or goals of the psychotherapy, which fall within the parameters of Medicaid-covered services, and be congruent with the diagnosis and initial evaluation of the client; and it must include a treatment regimen, projected schedule, and schedule for reevaluation. Documentation in the client's record should include written records of client contacts, services rendered, the role of the service to the care plan, and updates of the client's progress. The medical record must contain the notes that are countersigned or signed by the licensed individual to show that he or she personally reviewed the patient's medical history and confirmed the plan of care.
- Each psychotherapy or substance abuse treatment session must be written at the time the service is rendered and must be signed and dated by the therapist rendering the service. If the therapy session is rendered by an unlicensed therapist, and under the direct, personal supervision of a qualified, Medicaid enrolled provider, the therapy session must contain not only the dated signature of the therapist rendering the service but also the dated signature of the supervising provider. Each therapy session must contain the dated co-signature of the supervising provider on the date the service was rendered indicating that he or she has reviewed the note.
- The licensed supervisor does not have to be present in the room during the session, but must be in the facility during the session and meet regularly with the professional to discuss the client's plan of care and review the record. The record should indicate that the patient's progress and plan of care are reviewed at least after every six sessions by the supervising licensed professional. The clinical supervisor who

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monitors the performance of the person supervised must provide regular, documented face-to-face consultation, guidance, and education with respect to the clinical skills and competencies of the person supervised. For mental health services the focus of supervision and education should be on the mental health treatment provided by the supervisee. For substance abuse services the focus of supervision and education should be on the substance abuse treatment provided by the supervisee.

FREEDOM OF CHOICE

The patient shall have the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing:

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

Telephone Numbers:

804-270-5105 (Local)
 1-888-829-5373 (In state toll-free)
 804-270-7027 (Fax)

PARTICIPATION REQUIREMENTS PARTICIPATION REQUIREMENTS

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify FH/PEU, in writing, whenever there is a change in any of the information that the provider previously submitted.
- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Medicaid Program at the time the service was performed;
- Ensure the recipient's freedom to reject medical care and treatment;
- 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 basis of race, color, or national origin;

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- 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 services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public;
- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 states: "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. If a third-party payer reimburses \$5.00 out of an \$8.00 charge, and Medicaid's allowance is \$5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the \$3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative. The provider may not charge DMAS or the recipient for broken or missed appointments;
- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements;
- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the 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 must be retained until the audit is completed and every exception resolved (refer to the section on documentation of records);

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- Furnish to authorized state and federal personnel access to records and facilities in the form and manner requested;
- Disclose, as requested by DMAS, 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 medical assistance; and
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the state agency. The state agency shall not disclose medical information to the public.

PARTICIPATION CONDITIONS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements.

(See “Exhibits” at the end of the chapter for a sample of the form “Physician-Directed Provider Agreement” – DMAS-111.)

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual 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, all Medicaid providers are responsible for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the back of checks issued to providers, and, by endorsement, the provider indicates compliance with § 504 of the Rehabilitation Act.

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.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

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- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - The Department of Medical Assistance Services will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Department of Medical Assistance Services is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9, Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to:

Third-Party Liability Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

(Form DMAS 161 should be used for ordering the DMAS-1000. See "Exhibits" at the end of this chapter for a sample of the form "Third Party Liability Report" – DMAS-1000, and Chapter IV, for a sample of "Request for Forms" – DMAS 161.)

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see Chapter VI and the *Physician Manual* issued by DMAS.

FRAUD

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value

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for services rendered or supposedly rendered to recipients under Medicaid. A provider participation agreement will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V, "Billing Instructions," and Chapter VI, "Utilization Review and Control" of this manual.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 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
P.O. Box 26803
Richmond, VA 23261-6803

Additionally, Section 32.1-325 D.2 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 an offense classified as a felony in Virginia must immediately notify Medicaid of this conviction and relinquish the provider agreement.

RECONSIDERATION OF ADVERSE ACTIONS

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement.

A participating provider may terminate participation in Medicaid at any time; however, written notification of voluntary termination must be provided to FIRST HEALTH/Provider Enrollment Unit thirty (30) days prior to the effective date.

DMAS may terminate a provider from participation with thirty (30) days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice. Termination by DMAS shall be treated as an adverse action, and in certain instances the provider shall be entitled to a reconsideration and/or hearing as identified below.

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The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

If the denial is upheld, in whole or in part, as a result of the first-level informal appeal, the provider has the right to file for a second-level formal appeal, pursuant to Va. Code § 2.2-4020. The provider must file a request for a formal appeal within 30 days of receipt of the first-level informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

Section 32.1-325.D.2 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.

Repayment of Identified Overpayments

Pursuant to §32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum payment is not made, interest will be added to the unpaid balance at the statutory rate, pursuant to §32.1-313 of the Code of Virginia. Interest charges on the unpaid balance of any overpayment shall accrue from the date the Director's determination becomes final. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

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
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

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804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

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.

EXHIBITS

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Hospital Early Periodic Screening, Diagnosis, and Treatment Program Participation Agreement	1
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The exhibit listed below can be accessed on the DMAS website at www.dmas.virginia.gov.

- Mailing Suspension Request Form



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Hospital Early Periodic Screening, Diagnosis, and Treatment Program Participation Agreement

This is to certify:

Provider Name _____ NPI _____

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. The provider participating in the EPSDT program is one who is not identified in the State Plan.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. 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 (Section 504 of the Rehabilitation Act of 1973 29 USC.794) VMAP.
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 and 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 rendered will be based on the usual, customary, and reasonable concept 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 constitutes full payment except for patient pay amounts determined by VMAP, and 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 or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.
6. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. 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 administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party.
10. Except as otherwise provided by applicable state or federal law, 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.
11. The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. 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's use only	
Director, Division of Program Operations	Date

Original Signature of Provider Date