LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Dear Applicant:

Thank you for your interest in becoming a provider under the Hawaii State Medical Assistance Program (Medicaid). The enclosed brochure summarizes the services covered under this program.

Please complete and sign the enclosed application. Failure to sign the application and provide the requested information may result in the application being returned without action.

Required Forms:

- ❑ **Part A (Medicaid Application/Change Request Form)**
- ❑ **Part B & C (Provider Agreement and Condition of Participation)**
- ❑ **Part E (Disclosure Information)**

Optional:

- ❑ **Part D (Early & Periodic Screening, Diagnosis, and Treatment Provider Agreement)** Applicable only to providers who provide regular medical or dental services to individuals under the age of 21.

Please submit a copy of the following with your application. Failure to provide the information below may result in a delay in the processing of your application:

- ❑ **Current Hawaii State License to practice in the State of Hawaii**
- ❑ **Board Specialty Certificate or Letter of Board Eligibility (if applicable). DO NOT SEND diplomas in lieu of Board Specialty Certification, these will not be accepted.**
- ❑ **Advance Practice Registered Nurse Specialty and/or American Nurses Credentialing Center Certification (if applicable). Medicaid eligibles are pediatric, family, certified nurse midwife, and behavioral health nurses. All other nurses, please refer to Appendix 1.**
- ❑ **IRS Form W-9 (Request for Taxpayer Identification Number and Certification)**
- ❑ **Drug Enforcement Administration Certificate of Registration for Controlled Substances (if applicable)**
- ❑ **Certificate from the State of Hawaii Department of Public Safety-Narcotics Enforcement Division (if applicable)**
- ❑ **Hawaii General Excise Tax License (if applicable)**

- ❑ **CLIA Certificate (certificate of accreditation for laboratory services if applicable)**
- ❑ **NABP Certificate (certificate of accreditation for pharmacy if applicable)**
- ❑ **Notification letter of provider number from Medicare.**

The following providers will also need to complete an additional form:

- ❍ Psychiatrist or Psychologist
- ❍ Non-emergency transportation (taxi-cab)
- ❍ EPSDT Case Management
- ❍ Home Health Agency
- ❍ Nursing Facility (ICF or SNF)
- ❍ ICF-MR Facility
- ❍ EPSDT Skilled Nursing/Personal Care
- ❍ Acute Hospital

The following providers are required to submit a copy of the current approved certificate from the Department of Health-Office of Health Care Assurance with their application:

- ❍ Ambulatory Surgical Center
- ❍ X-Ray Supplier
- ❍ Dialysis Center
- ❍ SNF / ICF Facility
- ❍ Laboratory
- ❍ Home Health Agency
- ❍ Acute Care Facility
- ❍ ICF-MR Facility

If your application is approved you will receive a letter from the Med-QUEST Division with your new Medicaid provider number. The Medicaid Provider Manual will be sent to you from the State's Medicaid fiscal agent, Affiliated Computer Services (ACS).

If you have questions regarding the application packet, please call our office at (808) 692-8099 or (808) 692-8094. Questions relating to claims processing should be directed to ACS at 952-5570 on Oahu or toll-free at 1-800-235-4378.

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

MEDICAID APPLICATION / CHANGE REQUEST FORM

(PART A)

Please circle all that apply:

MEDICAID FEE-FOR SERVICE PROVIDER: (Y / N)	***ELECTRONIC REMITTANCE ADVICE: (Y / N)***
QMB ONLY PROVIDER: (Y / N)	***ELECTRONIC PROVIDER MANUAL: (Y / N)***

IS THIS A NEW MEDICAID APPLICATION (Y / N)
IS THIS A CHANGE REQUEST (Y / N)

SHADED FIELDS FOR MED-QUEST PROVIDER REGISTRATION STAFF ONLY ***Please Type or Print in Ink***

SECTION I

1) PROVIDER MEDICAID ID NUMBER *(Complete only if you are currently a participating Medicaid provider.)*	2) PROVIDER NAME *(Last Name/First Name/Middle Initial)*

3) PROVIDER'S REGISTERED BUSINESS NAME / DOING BUSINESS AS (d.b.a.) NAME

☐ SOLE PROPRIETORSHIP
☐ CORPORATION
☐ OTHER _____

4) SOCIAL SECURITY NUMBER	5) SPECIALTY / DEGREE *(Refer to Appendix 2)*
6) APPLICATION DATE Month _____Day _____Year _____	7) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED Month _____Day _____Year _____

SECTION II ADDRESS INFORMATION

☐ INITIAL SERVICE ADDRESS *(IF NEW APPLICANT)*
☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

CORRESPONDENCE ADDRESS (C)

8) ATTENTION TO:
9) STREET LINE 1:
10) STREET LINE 2:
11) CITY/STATE/ZIP:
12) BUSINESS PHONE: ( ) – 13) FAX NUMBER: ( ) –

SERVICE ADDRESS (S) — **DHS USE ONLY**

8) ATTENTION TO:
9) STREET LINE 1:
10) STREET LINE 2:
11) CITY/STATE/ZIP:
12) BUSINESS PHONE: ( ) – 13) FAX NUMBER: ( ) –
14) BEGIN DATE: / / 15) END DATE: / /
16) CLIA NUMBER: *If Applicable* 17) NABP/NCPDP NO.: *If Applicable*

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO E-MAIL ADDRESS:

PAY TO ADDRESS (P) — **DHS USE ONLY**

8) ATTENTION TO:
9) STREET LINE 1:
10) STREET LINE 2:
11) CITY/STATE/ZIP:
12) BUSINESS PHONE: ( ) – 13) FAX NUMBER: ( ) –
14) BEGIN DATE: / / 15) END DATE: / /
18) FEDERAL TAX ID NUMBER: 19) GENERAL EXCISE TAX NUMBER:

DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO

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☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)				**DHS USE ONLY**
8) ATTENTION TO:				
9) STREET LINE 1:				
10) STREET LINE 2:				
11) CITY/STATE/ZIP:				____
12) BUSINESS PHONE:	( ) –	13) FAX NUMBER:	( ) –	
14) BEGIN DATE:	/ /	15) END DATE:	/ /	
16) CLIA NUMBER: *If Applicable*		17) NABP/NCPDP NO.: *If Applicable*		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO		E-MAIL ADDRESS:		

PAY TO ADDRESS (P)				**DHS USE ONLY**
8) ATTENTION TO:				
9) STREET LINE 1:				
10) STREET LINE 2:				
11) CITY/STATE/ZIP:				____
12) BUSINESS PHONE:	( ) –	13) FAX NUMBER:	( ) –	
14) BEGIN DATE:	/ /	15) END DATE:	/ /	
18) FEDERAL TAX ID NUMBER:		19) GENERAL EXCISE TAX NUMBER:		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

☐ ADDITIONAL SERVICE LOCATION ☐ CLOSE EXISTING LOCATION ☐ CHANGE EXISTING INFORMATION

SERVICE ADDRESS (S)				**DHS USE ONLY**
8) ATTENTION TO:				
9) STREET LINE 1:				
10) STREET LINE 2:				
11) CITY/STATE/ZIP:				____
12) BUSINESS PHONE:	( ) –	13) FAX NUMBER:	( ) –	
14) BEGIN DATE:	/ /	15) END DATE:	/ /	
16) CLIA NUMBER: *If Applicable*		17) NABP / NCPDP NO.: *If Applicable*		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO		E-MAIL ADDRESS:		

PAY TO ADDRESS (P)				**DHS USE ONLY**
8) ATTENTION TO:				
9) STREET LINE 1:				
10) STREET LINE 2:				
11) CITY/STATE/ZIP:				____
12) BUSINESS PHONE:	( ) –	13) FAX NUMBER:	( ) –	
14) BEGIN DATE:	/ /	15) END DATE:	/ /	
18) FEDERAL TAX ID NUMBER:		19) GENERAL EXCISE TAX NUMBER:		
DO YOU WISH TO RECEIVE MAIL AT THIS ADDRESS? ☐ YES ☐ NO				

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SECTION III ADDITIONAL INFORMATION

LICENSING AND CERTIFICATION

20) LICENSE / CERTIFICATE NUMBER	21) LICENSING/CERTIFYING AGENCY	22) ISSUE DATE (MM/DD/YYYY)	23) EXPIRATION DATE (MM/DD/YYYY)

* A **COPY** OF THE LICENSE AND/OR CERTIFICATION **MUST BE ATTACHED**

BED COUNT INFORMATION - HOSPITALS, NURSING HOMES, AND HOSPICES ONLY

24) BED TYPE	25) STATE CERTIFIED COUNT	26) MEDICARE CERTIFIED COUNT	27) MEDICAID CERTIFIED COUNT	28) BEGIN DATE (MM/DD/YYYY)	29) END DATE (MM/DD/YYYY)

AUTHORIZED AGENTS

30) AGENT SIGNATURE	31) PRINT NAME	32) BEGIN DATE (MM/DD/YYYY)	33) END DATE (MM/DD/YYYY)

NOTE: THAT ALL SIGNATURES MUST BE ORIGINAL. ATTACHED A SEPARATE SHEET IF NEEDED.

GROUP BILLING AUTHORIZATION

34) GROUP NAME	35) ASSOCIATION BEGIN DATE (MM/DD/YYYY)	36) ASSOCIATION END DATE (MM/DD/YYYY)

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MEDICARE INFORMATION *(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #36)*

37) MEDICARE ID NUMBER	38) MEDICARE COVERAGE	FOR DHS USE ONLY		41) BEGIN DATE (MM/DD/YYYY)	42) END DATE (MM/DD/YYYY)
		39) INTERMEDIARY CODE	40) CARRIER CODE		

I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

43) PROVIDER SIGNATURE *(ONLY)* 44) DATE

45) PROVIDER NAME *(PLEASE TYPE OR PRINT*

FOR DHS USE ONLY - DETERMINATION

APPROVAL / DENIAL:

☐ FEE-FOR-SERVICE Provider ☐ QMB ONLY Provider *(Medicare Co-Payment / Deductible ONLY)*

☐ NEGOTIATED Provider *(Rates and/or Procedure Codes Attached)*

☐ APPROVED _____ (MM DD YY) ☐ DENIED _____ (MM DD YY) *REASON FOR DENIAL NOTATED BELOW*

REASON:: _____

MQD AUTHORIZED SIGNATURE DATE

FOR DHS USE ONLY - VALIDATION

PROVIDER TYPE:		ENROLLMENT BEGIN DATE:				DATE COS ENTERED: *Per Attached*			
	CODE		MM	DD	YY		MM	DD	YY

MQD AUTHORIZED SIGNATURE DATE

INSTRUCTIONS

FOR

NEW PROVIDERS

HAWAII STATE MEDICAID PROGRAM

Instructions for Completing the
Hawaii State Medicaid Program Provider of Service Information Form (DHS 1139)

PART A

NEW FEE-FOR-SERVICE (MEDICAID) OR QUALIFIED MEDICARE BENEFICIARY (QMB-ONLY) PROVIDERS

An applicant, hereby after referred to as "*provider*" must circle "Y" for Medicaid Fee-For-Service Provider. Note: Claims from an approved Medicaid Fee-For-Service provider will automatically crossover to Medicaid from Medicare if the provider's Medicare number was submitted to Medicaid.

Circle "Y" for the "QMB-Only Provider," if the *provider* is registering as an QMB-Only Provider. Please refer to **Appendix 1** for definition.

Circle "Y" for the "Electronic Remittance", if the provider wishes to receive electronic remittance advice rather than hard copy.

It is a requirement that a *provider* have at least one set of the Medicaid Provider Manual. Please circle "Y" for the "Electronic Provider Manual," if the *provider* wishes to receive the Medicaid Provider Manual on compact disk (CD) rather than hard copy paper form.

SECTION I PROVIDER INFORMATION

1.	Provider Medicaid Number:	Is this a new application? If *YES*, do not enter a number in this field proceed to item 2. Completion of this field is required only if the *provider* is currently participating in the State of Hawaii Medicaid Program and has a valid six-digit provider identification number and is submitting this form to update or change existing information. Please see "change" or "update" instructions.
2.	Provider Name:	Enter *provider's* Last Name, First Name and Middle Initial if the services will be rendered by an individual.
3.	Provider's Registered Business Name / Doing Business As (d.b.a.) Name	Enter the applicable Provider's Registered Business Name or Doing Business As (d.b.a.) Name. Please check the appropriate box indicating the type of business venture. If "Other," please specify in the space provided.
4.	Social Security Number:	Enter the *provider's* social security number, if the *provider* is any individual. Use of this number is for verification purposes only.
5.	Specialty Degree:	Enter the appropriate specialty /degree, which the *provider* has obtained through certification or letter of board eligibility. If unknown, refer to Appendix 2.

6.	Application Date:	Enter the date the *provider* completed the registration form.
7.	First Date of Service For Which a Claim Will Be Submitted:	Enter the *provider's* first date of service for which the *provider* will submit a claim to the State of Hawaii Medicaid Program. Failure to provide this information may result in claims being denied.

SECTION II ADDRESS INFORMATION

Please indicate by checking the appropriate box. Note: A NEW State of Hawaii Medicaid Fee-For-Service *provider* is required to have at least one (1) correspondence address location, one (1) in-state service address location, and one (1) pay-to address location at the time of application.

Correspondence Address – The address to which all Medicaid correspondence for the *provider* should be mailed.

Pay-to Address – The address to which payments for services rendered by the *provider* are to be mailed. Multiple service and pay to location addresses may be identified.

Service Address – The street address at which the *provider* renders services. All service locations must be identified. ***Exception: Physicians, e.g., independent anesthesiologists who have hospital privileges at various acute facilities need not list all these facilities. The physician may instead use his/her home address, commercial biller's address or wherever patient's billing records will be kept.***

A Post Office Box CANNOT be used for a service address; *provider* MUST list the actual physical location address. Rural service locations on the neighbor islands may add their physical location address on Street Line 1, and the Post Office Box on Street Line 2. The city, state and zip code must match Street Lines 1 & 2.

The following instructions may be used to complete the *provider's* correspondence, service, and pay-to addresses.

8.	Attention To:	Enter the person or department to whom all inquiries or correspondence should be addressed at the given address, if applicable.
9.	Street Line 1:	Enter the number and street address for the *provider*.
10.	Street Line 2:	Enter additional address information for the *provider*, if necessary.
11.	City, State/Zip/Code:	Enter the appropriate city associated with the *provider's* address information. Enter the appropriate 2-digit abbreviation identifying the state associated with the provider's address information. Enter the valid 5-digit code and 4-digit extension for the zip code associated with the *provider's* address.
12.	Business Phone:	Enter the telephone number (including area code), to be used when contacting the *provider* during normal business hours.

13. Fax Number: Enter the fax number (including area code), to be used when contacting the *provider* during normal business hours.

14. Begin Date: Enter the effective begin date for the address.

15. End Date: Enter the effective end date for the address, if applicable.

The following instructions are to be used to complete additional information related to the provider's service address.

16. CLIA Number: If the service address location is for a laboratory or laboratory services will be performed at this service address location, enter the Clinical Laboratory Improvement Amendments (CLIA) Laboratory Certificate of Accreditation number. Attach a copy of the CLIA certificate with this form.

17. NABP/NCPDP No.: Enter the National Association of Board of Pharmacy (NABP) or National Council for Prescription Drug Programs (NCPDP) certificate number if the service address is for a pharmacy. Attach a copy of the certificate with this form.

The following instructions are to be used to complete additional information related to the provider's pay to address.

18 Federal Tax ID Number: If the *provider* is a sole proprietor, indicate the applicable tax identification number (for 1099 reporting). If the *provider* is working for a Group, fill in the Federal Employer Identification Number (FEIN) for the group. If the *provider* is working for another provider, the applicable SSN or FEIN of the other provider ***(the group or employing provider must be actively participating in the State of Hawaii Medicaid Program)***.

A copy of the Form W-9, Request for Taxpayer Identification Number and Certification must be attached to this form and the name listed on Form W-9 form must match the Pay To Name exactly for the associated service address location. Failure to ensure that the Pay To Name is reported correctly may result in claims being denied.

19. General Excise Tax Number: If the *provider* is a sole proprietor, indicate the applicable tax identification number (for 1099 reporting). If the *provider* is working for a Group, fill in the Hawaii General Excise Tax number for the group. If the *provider* is working for another provider, enter the Hawaii General Excise Tax number of the other provider ***(the group or other provider must be actively participating in the State of Hawaii Medicaid Program).***

19. Continued Attach a copy of the General Excise Tax Certificate to this form; the

name listed on the General Excise Tax Certificate must match the Pay To Name exactly for the associated service address location. Failure to ensure that the Pay To Name is reported correctly may result in claims being denied.

For each service and pay-to address, please indicate if the *provider* wishes to receive mail at the address in addition to receiving mail at the *provider's* correspondence address by checking "Y" or "N".

SECTION III: ADDITIONAL INFORMATION

20. License Number:	Enter the appropriate identification number for the *provider's* license(s) or certification(s).
21. Licensing Agency	Enter the name of the agency that issued the *provider's* license or certification, e.g., State of Hawaii Department of Commerce and Consumer Affairs (SOH/DCCA), Drug Enforcement Administration (DEA), etc.
22. Issue Date:	Enter the date the license or certification was originally issued by the agency, including full century and year. *Note: The license or certification must cover dates of service the provider is requesting.*
23. Expiration Date:	Enter the date the license or certification expires.

For Hospitals/Nursing Homes and Hospices Only

24. Bed Type:	Enter the appropriate code indicating the level of care or type of beds the facility operates. Refer to Appendix 3 for corresponding codes.
25. State Certified Count:	Enter the appropriate number of state certified beds that the *provider's* facility operates, if applicable. List by level of care or bed type.
26. Medicare Certified Count	Enter the appropriate number of Medicare certified beds, which the *provider's* facility operates, which are MEDICARE certified, if applicable. List by level of care or bed type.
27. Medicaid Certified Count:	Enter the appropriate number of beds, which the *provider's* facility operates, which are MEDICAID certified, if applicable. List by level of care or bed type.
28. Begin Date:	Enter the date corresponding to the first date the *provider* began operation of these beds, if applicable.
29. End Date:	Enter the last date on which the *provider* was in operation of these beds, if applicable.
30. Agent Signature:	Individual(s) authorized to act as a signor on behalf of the *provider*

	for all Medicaid claims and claim correspondence must sign with his/her usual signature. If additional lines are required, please attach a separate list, the provider must sign on Item 43 of this form and any additional list to indicate his/her approval. *Note: The provider shall be the only person who can authorize and de-authorize an individual or individuals.*
31. Print Name:	Print the names of individuals whose authorized signature appears in the Agent Signature field.
32. Begin Date:	Enter the appropriate date on which the authorized agent's signature became effective.
33. End Date	Not applicable if this is a new application.
34. Group Name:	Enter the group name (commercial biller) authorized to bill on behalf of the *provider*, if applicable.
35. Association Begin Date:	Enter the date on which the *provider's* association with the group became effective, if applicable.
36. Association End Date:	Enter the date on which the *provider's* association with the group terminates, if applicable.
37. Medicare ID Number:	Enter the Medicare ID number assigned to the *provider* by Medicare, if applicable.
38. Medicare Coverage:	Enter the code indicating the type of Medicare coverage the *provider* is eligible to provide. Either Part A or Part B.
DHS USE ONLY	
39. Intermediary Code:	MQD shall enter the intermediary numeric code and Medicare Part A vendor's name if applicable.
DHS USE ONLY	
40. Carrier Code:	MQD shall enter the primary insurance carrier's numeric code or name associated with the *provider's* Medicare Part B number if applicable.
41. Begin Date:	Enter the date on which the *provider's* Medicare coverage began. Include full century and year.
42. End Date:	Enter the date on which the *provider's* Medicare coverage ends, if applicable.
43. Provider Signature:	This application is not valid unless signed by the *provider.*
44. Date:	Enter the date the *provider* signed this application.
45. Provider Name:	Please type or print the name of the individual whose signature appears in the Provider Signature field.

Filing Instructions for New Applicants & Updates to Provider Information:

Mail the form and all required documents to:

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Upon receipt of the Medicaid Application / Change Request Form (DHS 1139), the Health Coverage Management Branch will review the form in its entirety and make a determination as to your request for participation in the State of Hawaii Medicaid Program. If participation is approved you will be notified in writing by the State of your digit provider number (number assigned to each service location for claim filing purposes) and the approved effective date of participation as determined by the State.

A Medicaid provider number will be assigned to the service location and is to be used when filing claims for services rendered at this location only and cannot be used for any other service location the provider has. *(Exceptions: If a physician visits a patient of this service location in an acute facility, he will be allowed to use and submits a claim for services rendered to the patient while in the acute facility. Also, independent anesthesiologists due to the nature of their profession are excluded and are allowed to apply for one (1) Medicaid provider number with which to submit all claims regardless as to where the services were rendered.)*

If there are any questions regarding this form and its attachments; or, if additional copies of the form is needed; or, if you wish to inquire on the status of your application call the Health Coverage Management Branch at (808) 692-8099 or (808) 692-8094.

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

PART B AND PART C

Read through the Provider Agreement and Condition of Participation.

HAWAII STATE MEDICAID PROGRAM
PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION
(PART B)

I/We, _____, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

1. I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual.

2. I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L.94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.

3. I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid recipients and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).

4. I/We agree to disclose full and complete information regarding ownership and business transactions (42 C.F.R. §455.105), information on persons convicted of crimes (42 C.F.R. §455.106) at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.

5. I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

6. I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

7. I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.

8. I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17-1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.

9. I/We shall comply with the provisions of the Federal Drug Free Act of 1988 (P.L. 100-690), Title V, Subtitle D, which requires that the provider maintain a drug-free workplace.

10. I/We shall comply with the provisions of HIPAA. In this, Agreement "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. PROVIDER is a "health care provider" under HIPAA. A "covered entity" is a health care provider that transmits information in a standard electronic transaction under 45 C.F.R. Parts 160 and 162. If PROVIDER is or becomes a "covered entity", then PROVIDER must comply with all of the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions and code sets, and national employer and provider identifiers. Refer to 45 C.F.R. Parts 160, 162 and 164.

(PART C)

I/We understand that I/We may be suspended or terminated from participation in the Hawaii State Medicaid Program for non-adherence to any of the preceding program requirements and for violation of any of the provisions of H.A.R. Subtitle 12, Chapter 17-1704 (Provider Fraud) and Chapter 17-1736 (Provider Provisions) which includes but is not limited to the following:

(1) Any provider's practice which is deemed harmful to public health, safety and welfare of Medicaid recipients; (2) Not providing full and accurate disclosure of the identify of any person or persons who has been convicted of a criminal offense relating to Medicaid or Medicare; (3) Fraud against the Hawaii State Medicaid Program including, but not limited to, the claiming and receipt of payment or payments for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount entitled to; (4) Requiring and/or accepting any payment from a Medicaid recipient for services paid for by the Hawaii State Medicaid Program, except in cases where the Hawaii State Department of Human Services has identified a cost share to be paid by the recipient and where the recipient remits an amount equal to his or her cost share; (5) Requiring and receiving payment from a recipient to make up for the difference between the Hawaii State Department of Human Services' applicable fee schedule or rate and the provider's charges; (6) Revocation of the provider's license by the Hawaii State Department of Commerce and Consumer Affairs; (7) Withdrawal, expiration or termination of facility certification by the Hawaii State Department of Health; (8) Action taken by the provider's professional group or organization disapproving the provider's methods of treatment or care or a determination that care/services rendered by the provider are not in accordance with accepted practices of the profession or harmful to a recipient's health and safety; (9) Violation of the non-discrimination provisions; and (10) Notification from the Secretary of Health and Human Services, or person designated by him/her that an individual, hospital or nursing facility has withdrawn from participation in Medicare without refunding money it owes to Medicare or when the provider agreement has been terminated for defrauding Medicare.

IN THE CASE OF PROVIDERS WHO ARE INDIVIDUALS:

I agree that all services for which I make a claim against the Hawaii State Medicaid Program (Title XIX) will be personally rendered by me. Services such as administration of injections, immunizations, minimal dressings, and drawing of blood samples may be rendered by qualified support nursing staff.

I agree and understand that a qualified licensed psychiatrist or psychologist must provide all psychotherapeutic services, and qualified licensed clinical social worker or advance practice registered nurse shall be limited to behavioral health services.

IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal

Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Coverage Management Branch office subject to the discretion of the Med-QUEST Division administration. The month in which the application was received shall be counted as the first month.

I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.

_____

Print Name of Provider / Authorized Business Agent

_____

Signature of Provider / Authorized Business Agent

_____

Date of Signature

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROVIDER AGREEMENT (PART D)

I, as a Primary Care Provider (PCP) agree to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in accordance with Title 17, Chapter 1737, Subchapter 6, Section 53 to 62 of the Hawaii Administrative Rules.

I HAVE READ AND UNDERSTAND PART D OF THE AGREEMENT:

_____ _____

(Full Signature of Provider) (Date)

(Leave Blank if New Provider)

_____ _____

(Print Provider's Name in Full) (Medicaid Provider No.)

EFFECTIVE DATE REQUESTED:

_____

FOR DHS OFFICIAL USE ONLY

APPROVED: _____ _____

Contract Specialist Date

EFFECTIVE DATE OF PROVIDER PARTICIPATION: _____

MONTH/DAY/YEAR

Instructions for Completing the
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Agreement
(PART D)

Participation is optional; Provider approved by the Department of Human Services for program participation shall enter into a contractual agreement with the department. Contractual agreement shall include but not be limited to:

1) Provider's responsibility to maintain recipient's consolidated health history, including information received from other providers, and

2) Department's responsibility to reimburse for:

- ♦ Medical screening services based on a negotiated per patient rate; and
- ♦ Routine dental examinations in accordance with the fee schedule established for the fee for services component of the medical assistance program (Medicaid).

Please print or type your full name, date, sign, and give the effective date requested. If you are a new applicant, write "PENDING" in the space "Medicaid Provider No."

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

DISCLOSURE INFORMATION
(PART E)

As required by Hawaii Administrative Rules (§17-1736-20 & 17-1736-21) the following information must be submitted to the Med-QUEST Division prior to certification or renewal as a *provider* under Medicaid:

Information on Ownership and Control

1. List the names and addresses of each person who has an ownership or controlling interest in the disclosing entity (provider).

Name	Address	Relationship

2. List the name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Relationship

3. List the names of any other disclosing entity in which a person has an ownership or controlling interest in the disclosing entity and also has an ownership or controlling interest in the other disclosing entity.

Name	Address

Information Related to Business Transactions

1. List the ownership of any subcontractor (i.e., vendor) with whom your organization has had business transactions totaling more than $25,000 during the past 12-month period. (Attach list if necessary)

Describe Ownership (I.e., Corporation, Incorporated, etc.)	Dollar Amount of Transaction

2. List any significant business transactions between your organization and any wholly owned supplier or between your organization and any subcontractor during the past five-year period.

Name of Business	Type of Business Transaction

Information on Persons Convicted of Crime

1. List the names of any person who has ownership or controlling interest in the Provider, or is an agent, managing employee, or employee of the Provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Position

I/We hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I/We understand that if I knowingly or willfully make or cause to make a false statement or representation on the statement, I/We may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in the Medicaid Program.

Further, the Provider shall, upon discovery of any information required by federal and state regulations, immediately notify the Med-QUEST Division in writing of the information required to be provided.

Date Signed	Print Name of Provider / Authorized Business Agent
	Signature of Provider / Authorized Business Agent

Instructions for Completing the Disclosure Information Form (PART E)

The disclosure of this information to the Medicaid Agency **is a federal requirement.** Information must be furnished to the Medicaid Agency within 35 days of a written request per federal regulations (§455.104(3), §455.105(b), and §455.106). **Department of Human Services (DHS) may refuse to enter into a contract and may suspend or terminate an existing agreement if the provider fails to disclose ownership or controlling information and related party transactions.**

Definitions relative to the disclosure form are attached to help in completing the form. Please do not leave sections blank. If there is no information to include, indicate "None" in the space provided.

Information on Ownership and Control

1) List the name and address of the person(s) who has an ownership or controlling interest in your practice / company / business. Ownership by another individual, company or business entity need not be listed.

2) List the name and address of the person(s) from your company who also has an ownership or controlling interest in any subcontractor (i.e., vendor) you utilize and which your company/business has direct or indirect ownership of 5 percent (5%) or more. Please indicate if the person listed is related to another as spouse, parent, child, or sibling to those individuals or organizations with an ownership or controlling interest.

3) List the names of any "Other Disclosing Entity" who has an ownership or controlling interest in your company/business and has ownership or a controlling interest in the "Other Disclosing Entity." The "Other Disclosing Entity" does not have to be a participating Medicaid provider; but does participate in other government programs such as Medicare. These "Other Disclosing Entity" may include a hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, or health maintenance organization that participates in Medicare.

Information Related to Business Transactions

1) List the ownership of any subcontractor (i.e., vendors) with whom the disclosing entity has had business transactions totaling more than $25,000 during the past 12-month period. You may provide a print of your Accounts Payable record that also indicates the amount paid (totaling more than $25,000) and attach it to the form.

   You may request the ownership information in writing from the individual or subcontractor and document their responses to you. You are required to advise the Medicaid Agency when there is no response from the individual or subcontractor to your request for this information.

2) List any significant business transactions between the disclosing entity and any wholly owned supplier or between the disclosing entity and any subcontractor during the past five-year period.

DEFINITIONS FOR DISCLOSURE OF INFORMATION FORM

"Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

"Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

"Disclosing entity," means a Medicaid provider and/or Medicaid applicant.

"**Other Disclosing Entity**" means any other Medicaid disclosing entity and 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 (Maternal & Child Health Services), Title XVIII (Medicare), or Title XX (Grants to States for Social Services). This includes:

1) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare.

2) Any Medicare intermediary or carrier, and

3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX (Medicaid) of the Social Security Act.

"Fiscal agent" means a contractor that processes or pays vendor claims on behalf of the Department of Human Services.

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

"Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

"Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

"Person with an ownership or controlling interest" means a person or corporation that:

1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

5) Is an officer or director of a disclosing entity that is organized as a corporation; or

6) Is a partner in a disclosing entity that is organized as a partnership?

"Significant business transaction" means any business transaction or series of transactions that, during one fiscal year exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

"Subcontractor" means:

1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under its DHS agreement (e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pharmaceutical firm).

"Wholly owned subsidiary supplier," means a subsidiary or supplier whose total ownership interest is held by the Medicaid provider/applicant or by a person, persons, or other entity with an ownership or controlling interest in the Medicaid provider/applicant.

INSTRUCTIONS

FOR

EXISTING PROVIDERS

HAWAII STATE MEDICAID PROGRAM

Instructions for Completing the
Hawaii State Medicaid Program Provider of Service Information Form (DHS 1139)

CURRENT PARTICIPATING STATE OF HAWAII MEDICAID PROVIDER UPDATES TO INFORMATION

Select the corresponding change being requested and complete the DHS 1139 (Part A) Sections I and II and follow the instructions listed under each provider change request.

For individual providers, complete the following:

- ❑ **Adding An Additional Service Address:**

  Section I
  - Medicaid Provider ID Number
  - Provider Name
  - Provider's Registered Business Name / Doing Business As (d.b.a.) Name

  Section II Address Information
  - Complete correspondence address, if applicable.
  - Complete service address to be added (item 8 through item 15). If item 16 or item 17 applies, submit a copy of the required certificate.
  - Corresponding pay to address for this new service address and applicable federal tax identification number.
  - Begin date of address (if date not provided, MQD will use date request received).
  - Indicate whether *provider* wishes to receive mail at the new service or pay to address.
  - Provider's signature on documented request.
  - Letters in lieu of the DHS 1139 are acceptable, if signed by *provider* and includes the above information.
  - Submit a signed IRS Form W-9, Request for Taxpayer Identification Number and Certification.

- ❑ **Add/Close A Service Address:**

  Section I
  - Medicaid Provider ID Number
  - Provider Name
  - Provider's Registered Business Name / Doing Business As (d.b.a.) Name

  Section II – Address Information – *(Service Location To Be Added)*
  - Complete correspondence address, if applicable.
  - Complete service address to be added (item 8 through item 15). If item 16 or item 17 applies, submit a copy of the required certificate.
  - Corresponding pay to address for this new service address and applicable federal tax identification number.

- Begin date of address (if date not provided, MQD will use date request received).
- Indicate whether *provider* wishes to receive mail at the new service or pay to address.
- Provider's signature on documented request.
- Letters in lieu of the DHS 1139 are acceptable, if signed by *provider* and includes the above information.
- Submit a signed IRS Form W-9, Request for Taxpayer Identification Number and Certification.

Section II – Address Information – *(Service Location To Be Closed)*

- Complete service address to be closed. End date of address (if date not provided, MQD will use date request received).
- Corresponding pay to address for this new service address and applicable federal tax identification number.

❑ **Changing Correspondence And/Or Pay To Address Only:**

Section I

- Medicaid Provider ID Number
- Provider Name or Registered Business Name

Section II Address Information

- Indicate the NEW correspondence and/or pay to address and existing service location(s) affected by the change.
- New tax payer identification number (sole proprietor to sole proprietor or sole proprietor to corporate, *provider* must submit a signed IRS Form W-9 or letter of notification of number and a copy of your General Excise Tax Certificate, if applicable). *If sole proprietor to corporate, provide must complete a new Disclosure Information Form (Part E)*.
- If a begin date is not provided, MQD will use the date of your request.
- Provider's signature on documented request.

NOTE: A COMMERCIAL BILLER (E.G., TEAMPRAXIS, HPAS, ETC.) SERVICE (ADMINISTRATIVE OFFICE) LOCATION CAN ONLY BE USED, AS A *PROVIDER'S* CORRESPONDENCE & PAY TO ADDRESS.

For Laboratories And Pharmacies:

❑ Adding a Service Address:

Section I

- Medicaid Provider ID Number.
- Provider's Registered Business Name / Doing Business As (d.b.a.) Name.

Section II Address Information

- Complete Correspondence address, if applicable.

- Complete Service address to be added item 8 through item 15. Enter required applicable information on item 16 or item 17, *submit a copy of the required certification or Hawaii State license*.
- Corresponding Pay To address for this new service address and applicable federal tax identification number.
- Begin date of address (if date not provided, MQD will use date request received)
- Indicate whether provider wishes to receive mail at the address
- Provider's signature on documented request
- Letters are acceptable, if signed by *provider* and includes the above information.
- Submit a signed IRS Form W-9, Request for Taxpayer Identification Number and Certification.

Changes in Ownership

❑ Solo to Solo: Social Security Number (SSN) to Federal Employer Identification Number (FEIN), individual incorporation only, does not include partnerships.

Provider must provide either a letter or a DHS 1139 (Part A) that includes the following listed information:

Section I

- Medicaid Provider ID Number
- Provider Name
- Provider's Registered Business Name / Doing Business As (d.b.a.) if a name change has occurred.
- Either a letter from the IRS indicating an employer identification number or a signed IRS Form W-9.
- Copy of State General Excise Tax registration number if applicable.
- Date of change (if date not provided, MQD will use date request received)

Section II Address Information

- Correspondence, Service and Pay To Addresses that may be affected by this change

Change In Participation

❑ Group Participation (Employed) to Sole Proprietor

Complete DHS 1139, Parts A, B&C, D and Part E if applicable.

What is QMB?

"QMB Program" means Qualified Medicare Beneficiary Program. As a result of Section 301 of the Medicare Catastrophic Coverage Act of 1988, the Department of Human Services will provide Qualified Medicare Beneficiary (QMB) coverage to recipients with Medicare coverage meeting the eligibility criteria for this program. Under this program, the State Medicaid Program will pay for the recipients' Medicare premiums, and any coinsurance and/or deductible to providers rendering services.

"QMB-Only Provider" means a provider who does not meet the eligibility criteria for Medicaid; but, is providing Medicare eligible services and wants to be eligible to bill for services rendered to QMB/Medicaid recipients. No payment will be made to providers not participating under the QMB Program. Claims submitted from providers not identified as a QMB or QMB-Only provider will be denied.

"QMB/Medicaid" means recipients with dual coverage; these recipients however must be treated as Medicaid patients. Medicare assignment must be accepted and claims will cross over to Medicaid for coordinated processing.

"QMB Only Payments" means payments processed for the coinsurance and/or deductible for services covered under Medicare to QMB/Medicaid recipients through the State's Medicaid fiscal agent. No payment will be made toward services not covered by Medicare even if the services are a benefit of the Medicaid Program.

"QMB/Medicaid Payments" means payments processed for the coinsurance and deductible for Medicare covered services to recipients with dual coverage through the State's Medicaid fiscal agent. Any service not covered by Medicare but covered under Medicaid will also be paid; however, a separate claim may need to be submitted to Medicaid for these Medicare non-covered services.

APPENDIX 2

SPECIALTY / DEGREE

CODE	DESCRIPTION
175	ACUPUNCTURIST
951	ADDICTION MEDICINE
180	ADMINISTRATIVE MEDICINE
176	ADOLESCENT MEDICINE
185	AEROSPACE MEDICINE
011	ALLERGIST
010	ALLERGIST/IMMUNOLOGIST
952	ANATOMIC PATHOLOGY
135	ANATOMICAL/ CLINICAL PATHOLOGY
020	ANESTHESIOLOGIST
925	AUDIOLOGIST
410	BACTERIOLOGY
131	BLOOD BANKING
464	BLOOD GROUPING/RH TYPING
953	BRONCHO-ESOPHAGOLOGY
927	CARDIOLOGIST
062	CARDIOVASCULAR MEDICINE
954	CHEMICAL DEPENDENCY
955	CHEMICAL PATHOLOGY
510	CLINICAL CHEMISTRY
251	CRITICAL CARE MEDICINE
501	CROSSMATCHING
809	DENTIST - ANESTHESIOLOGIST
802	DENTIST - ENDODONTIST
803	DENTIST - ORAL PATHOLOGIST
808	DENTIST - ORAL SURGEON
801	DENTIST - ORTHODONTURE
804	DENTIST - PEDODONTIST
806	DENTIST - PERIODONTIST
805	DENTIST - PROSTHODONTIST
807	DENTIST - PUBLIC HEALTH
800	DENTIST-GENERAL
040	DERMATOLOGIST
143	DERMATOPATHOLOGY
956	DIABETES
957	DIAGNOSTIC LABORATORY IMMUNOLOGY
913	DIALYSIS
504	EKG SERVICES
250	EMERGENCY MEDICINE
901	EMERGENCY ROOM PHYSICIANS
063	ENDOCRINOLOGIST

APPENDIX 2

CODE	DESCRIPTION
540	EXEFOLIATIVE CYTOLOGY
714	EYE (LOW VISION SPECIALIST)
050	FAMILY PRACTICE
136	FORENSIC PATHOLOGY
064	GASTROENTEROLOGIST
055	GENERAL PRACTICE
019	GENETICIST
082	GERONTOLOGIST
958	GYNECOLOGICAL ONCOLOGY
090	GYNECOLOGIST
065	HEMATOLOGIST
970	HEMATOLOGY & ONCOLOGY
574	HISTOCOMPATABILITY
074	HISTOPATHOLOGY
077	HOMEOPATHIC
178	HYPNOTIST
490	IMMUNOHEMATOLOGY
012	IMMUNOLOGIST
959	IMMUNOPATHOLOGY
971	INDUSTRIAL MEDICINE
066	INFECTIOUS DISEASES
060	INTERNAL MEDICINE
122	LARYNGOLOGIST
960	LEGAL MEDICINE
092	MATERNAL AND FETAL MEDICINE
138	MEDICAL CHEMISTRY
969	MEDICAL TOXICOLOGY
400	MICROBIOLOGY
071	MSW SOCIAL WORKER
450	MYCOLOGY
096	NEONATAL NURSE PRACTITIONER
961	NEOPLASTIC DISEASES
067	NEPHROLOGIST
075	NEUROLOGIST
141	NEUROPATHOLOGY
799	NO SPECIALTY REQUIRED
080	NUCLEAR MEDICINE
081	NUCLEAR PHYSICS
962	NUCLEAR RADIOLOGY
187	NUTRITIONIST
091	OBSTETRICIAN
089	OBSTETRICIAN AND GYNECOLOGIST
183	OCCUPATIONAL MEDICINE

APPENDIX 2

CODE	DESCRIPTION
241	ONCOLOGIST
100	OPHTHALMOLOGIST
015	OPTICIAN
600	OPTOMETRIST
532	ORAL PATHOLOGY
950	ORTHOPEDIST
972	OSTEOPATHIC MANIPULATIVE MEDICINE
161	OSTEOPATHIC MANIPULATIVE THERAPY
999	OTHER
585	OTHER CLINICAL CHEMISTRY
073	OTHER IMMUNOHEMATOLOGY
072	OTHER MICROBIOLOGY
437	OTHER SEROLOGY
120	OTOLARYNGOLOGIST
124	OTOLOGIST
935	OTORHINOLARYNGOLOGIST (ENT)
964	PAIN CONTROL
460	PARASITOLOGY
530	PATHOLOGY
967	PATHOLOGY, RADIOISOTOPIC
155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
191	PEDIATRIC - PSYCHIATRIST
157	PEDIATRIC ALLERGIST
151	PEDIATRIC CARDIOLOGIST
156	PEDIATRIC ENDOCRINOLOGIST
152	PEDIATRIC HEMATOLOGIST
963	PEDIATRIC HEMATOLOGY-ONCOLOGY
154	PEDIATRIC NEPHROLOGIST
076	PEDIATRIC NEUROLOGIST
943	PEDIATRIC ORTHOPEDIST
159	PEDIATRIC PULMONARY DISEASE
150	PEDIATRICIAN
188	PHARMACOLOGIST
160	PHYSICAL MEDICINE/ REHABILITATION
798	PHYSICIAN ASSISTANT
503	PHYSIOLOGICAL TESTING
650	PODIATRIST
470	PREGNANCY TESTING
182	PREVENTIVE MEDICINE
900	PROCEDURES - ANY CERTIFIED LABORATORY
973	PROCTOLOGY
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER
192	PSYCHIATRIST

APPENDIX 2

CODE	DESCRIPTION
195	PSYCHIATRIST AND NEUROLOGIST
965	PSYCHOANALYSIS
083	PSYCHOLOGIST
189	PSYCHOSOMATIC MEDICINE
184	PUBLIC HEALTH
068	PULMONARY DISEASES
550	RADIOBIOASSAY
200	RADIOLOGY
201	RADIOLOGY - DIAGNOSTIC
968	RADIOLOGY - ONCOLOGY
158	RADIOLOGY - PEDIATRIC
205	RADIOLOGY - THERAPEUTIC
974	REHABILITATION MEDICINE
093	REPRODUCTIVE ENDOCRINOLOGIST
966	RETIRED
500	RH TITERS
069	RHEUMATOLOGIST
125	RHINOLOGIST
097	RN ADULT NURSE PRACTITIONER
084	RN FAMILY NURSE PRACTITIONER
088	RN GERIATRIC NURSE PRACTITIONER
094	RN MIDWIFE
086	RN PEDIATRIC NURSE ASSOCIATE
087	RN PEDIATRIC NURSE PRACTITIONER
085	RN SCHOOL NURSE PRACTITIONER
975	ROENTGENOLOGY (DIAGNOSTIC)
511	ROUTINE CHEMISTRY
976	SCLEROTHERAPY
430	SEROLOGY
162	SPORTS MEDICINE
210	SURGERY
211	SURGERY - ABDOMINAL
212	SURGERY - CARDIOVASCULAR
030	SURGERY - COLON/RECTAL
219	SURGERY - GYNECOLOGICAL
213	SURGERY - HAND
214	SURGERY - HEAD AND NECK
215	SURGERY - MAXILLOFACIAL
070	SURGERY - NEUROLOGY
181	SURGERY - OBSTETRICAL
441	SURGERY - OPTHALMOLOGICAL
977	SURGERY - ORAL & MAXILLOFACIAL
110	SURGERY – ORTHOPAEDIC

APPENDIX 2

CODE	DESCRIPTION
153	SURGERY - PEDIATRIC
170	SURGERY - PLASTIC
171	SURGERY - PLASTIC OTOLARYNGOLOGICAL FACIAL
484	SURGERY - PODIATRIST
220	SURGERY - THORACIC
216	SURGERY - TRAUMA
217	SURGERY - UROLOGICAL
218	SURGERY - VASCULAR
431	SYPHILIS
166	THERAPIST - OCCUPATIONAL
167	THERAPIST - PHYSICAL
165	THERAPIST - SPEECH
524	URINALYSIS
230	UROLOGIST
440	VIROLOGY
095	WOMEN'S HEALTHCARE/OB-GYN NURSE PRACTITIONER

APPENDIX 3

BED TYPES CODES

CODE	DESCRIPTION
ACUT	ACUTE BEDS
ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS