	GUAM MEDICAID AND MIP PROVIDER ENROLLMENT APPLICATION CHECKLIST
☐	**Copy of Federal Taxpayer Identification Number (TIN) / Employer Identification Number (EIN).**
☐	**Copy of Business License (On-Island providers' copy of Guam Fictitious Certificate/Certificate of Exemption/Business License) at the physical location and must match business name on the Federal W-9 Form.**
☐	**Copy of Provider or Authorized Official's picture and signature identification (Passport, Medical License, Driver's License).**
☐	**Completed Federal W-9 Form. The business name, mailing address, and TIN / EIN.**
☐	**Completed DOA Vendor Record & EFT Establishment Request Form w/ Voided Check or Personalized Deposit Slip.**
☐	**Copy of Business National Provider Identifier (NPI - 10 Digits).**
☐	**Physician Services: Copy of Health Care Professional's NPI - 10 Digits, Specialties/Subspecialties Certification (if applicable), Medical License (On-Island providers' copy of *a Guam Medical License*), and Drug Enforcement Administration (DEA) License.**
☐	**Hospital/Facility Services: *Requires an Addendum Agreement for negotiated reimbursement rate / per diem rate.***
☐	**Pharmacy Services: Copy of Pharmacist's Professional NPI - 10 Digits, Medical License (On-Island providers' copy of *a Guam Medical License*), and Drug Enforcement Administration (DEA) License.**
☐	**Dental Services: Copy of Dentist's Professional NPI - 10 Digits, Medical License (On-Island providers' copy of *a Guam Medical License*), and Drug Enforcement Administration (DEA) License.**
☐	**Laboratory Services: Copy of Clinical Laboratory Improvement Amendments (CLIA) Certificate.**
☐	**Radiology Services: Copy of Health Care Professional's NPI - 10 Digits, and Medical License (On-Island providers' copy of *a Guam Medical License*).**
☐	**Copy of Medicare Certification / Approval Letter: When enrolled in the Medicare Program and for dual eligible recipients.**
☐	**Copy of the Business Associate Agreement (BAA) / Business Service Agreement (BSA) with Billing Agent.**

GUAM MEDICAID AND MEDICALLY INDIGENT PROGRAM (MIP)
PROVIDER ENROLLMENT APPLICATION

I HEREBY APPLY TO PARTICIPATE AS A PROVIDER AND REQUEST FOR ASSIGNMENT OF A VENDOR NUMBER FOR THE PAYMENTS, PROVIDER IDENTIFICATION NUMBER FOR THE CLAIMS, AND PROVIDER USER IDENTIFICATION NAME FOR THE PORTAL.

☐ **INITIAL APPLICATION** ☐ **RENEWAL APPLICATION**

PROVIDER NAME: _____

BUSINESS/CORPORATION NAME: _____

Doing Business As (D.B.A.): _____

TIN/EIN: _____ NPI #: _____

BUSINESS LICENSE #: _____

*** Guam Business License is required, GCA Title 11 Chapter 70, when engaging in/conducting a business on Guam.**

BUSINESS LICENSE TYPE : _____

GUAM BUSINESS LICENSE # / TYPE:

BUSINESS PHYSICAL ADDRESS: _____

_____

_____

BUSINESS MAILING ADDRESS: _____

_____

EMAIL: _____

TEL: _____ FAX: _____

CONTACT INFORMATION

NAME: _____ TITLE: _____

EMAIL: _____

TEL: _____ FAX: _____

PROFESSIONAL SERVICES PROVIDER REQUIREMENTS

PLEASE LIST PARTICIPATING PHYSICIANS OR HEALTH PROFESSIONALS PROVIDING SERVICES AND THEIR REQUIRED INFORMATION. PROVIDE A COPY OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS)/SUBSPECIALTIES CERTIFICATION, NPI, CURRENT MEDICAL LICENSE, DEA LICENSE, AND DIPLOMA (IF APPLICABLE).

NAME	SPECIALTY/SUBSPECIALITY	NPI#	MEDICAL LICENSE#	ISSUE DATE	EXP DATE

☐ **BILLING AGENT: Provide a copy of the Business Associate Agreement / Service Contract Agreement.**

BILLING AGENT BUSINESS NAME: _____

STAFF NAME: _____ STAFF TITLE: _____

EMAIL: _____ TEL: _____ FAX: _____

☐ **EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM PROVIDER:**
The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid performed by licensed physician.

The PROVIDER agrees:

1. To adhere to professional standards of medical or paramedical care and / or services and to comply with the Program's policies and procedures pertinent to the Provider's performance under this agreement;
2. To keep and permit access to such records as are necessary to disclose fully the extent of the services provided to the Medicaid / MIP recipients.
3. To disclose full and complete information regarding ownership and business transactions at the request of the Department, the Secretary of the Department of Health and Human Services, or the Bureau of Investigations and Benefits Recovery Unit.
4. To furnish the Department and the Secretary of the Department of Health and Human Services any information regarding payments claimed for services provided to eligible Medicaid / MIP recipients in accordance with the Medicaid State Plan, the Territorial laws and Government of Guam Rules and Regulations, as the Department or the Secretary may from time to time
5. To accept the established Guam Medicaid / Medically Indigent Programs reimbursement rates and payments as full payment and not to bill, accept or retain payment from patients or relatives for any additional amount other than the required co-payment and co-shares and payments for non-covered services;
6. To utilize patient's medical insurance resources, including but not limited to Medicare, private insurance, and insurance provided by employers and unions, before submitting claims to the Medicaid / MIP;
7. To submit all charges within one (1) year after service date except for Medicaid and MIP with Third Party Liability (TPL) which should be submitted within sixty (60) additional days from the receipt date of the TPL payments/statements;
8. To submit all claims/bills to the following address:
   DPHSS BHCFA Medicaid and MIP Program
   Ran Care Building CBU#106
   761 South Marine Corps Drive
   Tamuning, Guam 96913
   Telephone Number: (671) 300-7330 / 7331 / 7335 / 7336 / 7337 / 7341 / 7353
   Fax Number: (671) 300-7354
9. To assume total responsibility for collecting required patient co-payments, co-insurances and other patient liabilities;
10. To have in effect for hospitals, a Utilization Review Plan to assure the necessity of admission, length of stay, and the level of care appropriateness as required by 42 CFR 456.80 and 456.100.
11. To abide by the provisions of the Civil Rights Act of 1964, specifically stating that "no persons in the United States shall, on the grounds of race, creed, color, national origin, or handicapping condition, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal Financial Assistance;
12. That this agreement may be terminated by a 30-day written notification by the Director of the Department of Public Health & Social Services (DPHSS) and a change of ownership, and revalidated at least every 5 years;
13. That violation of any of the terms in this agreement may result in withholding of payment, suspension/termination from participation, or as in accordance with the terms of 42 CFR 455;
14. That all claims for services rendered to Medicaid / MIP recipients are provided by qualified, licensed health professionals;
15. That retroactive provider certification shall be limited to the first day of the third month from date the completed application has been credentialed. The month in which the completed application was received shall be counted as the first month. Upon approval for participation, Bureau of Health Care Financing Administration (BHCFA) will notify via email along with your vendor number, provider identification number, and provider user identification name and password, and orientation as requested;
16. To provide the BHCFA any operation updates as soon as changes are in effect to include the list of physicians or any health

The DEPARTMENT agrees:

1. To reimburse Provider for covered services in accordance with the program covered benefits.
2. To process all "clean" claims within forty-five (45) days after receipt of invoices from Provider. Clean claims are claims that can be processed without obtaining additional information and/or documentation from the Provider of the service.
3. To reimburse the Provider for program recipient's deductible, coinsurance, and/or co-payment from the recipient's primary insurance/Third Party Payor, not to exceed the programs fee schedule for the service.

I have read the agreement of the Guam Medicaid and MIP Provider Enrollment Application, and fully understand and agree to the terms and conditions provided therein.

AUTHORIZED OFFICIAL'S NAME	**TITLE**
AUTHORIZED OFFICIAL'S SIGNATURE	**DATE**

DEPARTMENT APPROVAL

AUTHORIZED DPHSS'S NAME	**TITLE**
AUTHORIZED DPHSS'S SIGNATURE	**DATE**

FOR BHCFA USE ONLY

EFFECTIVE DATE: _____ **TERMINATION DATE:** _____

PROVIDER ID #: _____ **VENDOR #:** _____

PORTAL PROVIDER USER IDs: _____

CLAIMS INFORMATION

CATEGORY OF SERVICE: _____ ❑Facility ❑Group ❑Individual

ASSOCIATED CLAIM CATEGORY: ❑Dental ❑Hospital ❑Pharmacy ❑Physician