For Fiscal Agent Internal Use Only

Practitioner Name: _____

Doc Type: Ordering/Refer _____ Practitioner Type: _____ Practitioner Specialty: _____

NPI Number : _____

SS#: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

*PRESCRIBING/ORDERING/REFERRING/ATTENDING PHYSICIAN OR OTHER PROFESSIONAL APPLICATION

Practitioner Name: _____

NPI Number: _____ **Date of Birth:** _____

Practitioner Address: _____
Street City State Zip

Practitioner Contact Name: _____ **Contact Phone #** _____

Email Address_____ **Fax Number:** _____

Type of Service:_____ **SS #:** _____ **Tax ID:**_____

Physician Specialty _____ **Non-Physician Speciality:**_____

If applicable, what was the earliest date that a service was provided to a Medicaid recipient: _____

IF APPLICABLE APPLICANTS MUST REPORT THE FOLLOWING INFORMATION

Medicare #: _____ **Lab-CLIA #** _____ **State Medical License #**_____

State of Licensure: _____ **Federal DEA Registration No.** _____

State CDS Registration No. _____ **State of CDS Registration** _____

Medicaid Provider # and State: _____ **Certification No.** _____

Type of Certification _____ **Certifying Entity:** _____

State of Certification _____

* You must attach a copy of current License(s), Registration(s) and/or Board Certification(s) and complete the practitioner certification on Page 3

PRESCRIBING/ORDERING/REFERRING/ATTENDING PHYSICIAN OR OTHER PROFESSIONAL APPLICATION

42 CFR 455.410 requires all ordering/referring/attending physicians or other professionals providing services covered by the NJFC/Medicaid program to be enrolled as participating providers. Applicants as ordering/referring/attending physicians or other professionals are not authorized to bill or receive New Jersey FamilyCare (NJFC)/Medicaid reimbursement from the State of New Jersey and are required to comply with all applicable State and federal laws, rules and regulations in regard to providing a healthcare service(s) to a NJFC/Medicaid beneficiary.

Final Adverse Actions /Convictions

The section below defines the convictions and final adverse that must be reported in this application regardless of whether any records were expunged or any appeals are pending.

Convictions:

1. The physician or non-physician practitioner was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare or Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

2. Any revocation or suspension of accreditation.

Exclusions, Revocations, or Suspensions (continued)

3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

4. Any current Medicare payment suspension under any Medicare Identification Number.

5. Any Medicare revocation of any Medicare Identification Number.

Have you, under any current or former name or business identity, ever had any final adverse legal action(s) listed under **Convictions, Exclusions**, **Revocations, or Suspensions** of this application imposed against you? Yes ☐ No ☐

If yes, on a separate sheet of paper report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the final adverse legal action documentation and resolution.

Practitioner's Certification:

I certify that the foregoing information provided in this application, for the sole purpose of ordering/referring/attending services to a NJFC/Medicaid beneficiary, is true, accurate and complete; and I also acknowledge that providing any false statement, or false document, or concealment of a material fact may be prosecuted under applicable federal or state laws.

Also, by signing this application, I consent to a possible civil and criminal background check by DMAHS and/or by the Medicaid Fraud Division of the Office of the State Comptroller. I understand that if the results of this background check are unsatisfactory, the Division of Medical Assistance and Health Services may refuse to allow the applicant to order/refer/attend services to a NJFC/Medicaid beneficiary.

_____	_____	_____
Signature of Practitioner **Original Signature Required - No Stamps**	**Print Name**	**Date**
_____	_____	_____
Signature of Person Completing Form	**Print Name**	**Date**

Thank you for taking the time to enroll as an ordering/referring/attending physician or other professional in the NJFC/Medicaid program as required by Federal regulations. Please be advised that you are **NOT** required to see Medicaid clients after enrolling as non-billing provider. Please mail the signed application with required documentation to:

Gainwell Technologies Provider Services
P.O. Box 4804
Trenton, NJ 08650

You can also fax the completed application with credentials to: 609-584-1192.

If you have any questions, Gainwell Technologies Provider Services can be reached at 609-588-6036.