STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

Public Health Crisis Provisional Enrollment

By completing and signing this Provisional Enrollment Application, I am giving permission for NJ FamilyCare/Medicaid to share my information that I provide on this application with each of the NJFC managed care organizations (MCOs) for potential provider enrollment: Aetna Better Health of New Jersey, Amerigroup New Jersey, Horizon NJ Health, UnitedHealthcare Community Plan and Wellcare.

Note: *If you want to apply to fee-for-service Medicaid/NJFC only without your information being shared with the NJFC MCOs, the standard application form should be used, which can be found at www.njmmis.com.*

Provider Name_____ **NPI Provider #** _____

Provider Address _____ _____ _____ _____
Street City State Zip

Provider Contact Name _____ **Business Phone #** _____

Mobile Phone# _____ **May we communicate with you via text? ____Yes / ____No**

Email Address _____ **Fax Number**_____

Requested Service Date(s) _____ **Type of Service**_____

SS #_____ **Tax ID #**_____ **Date of Birth: ____/____/____**

State License #_____ **State of Licensure (if not New Jersey)**_____

Medicare #_____ **UPIN #** _____ **Lab-CLIA #** _____ **Medicaid Provider #** _____

DEA Permit #_____ **Effective Date**_____ **Expiry Date** _____ **CDS #** _____

Specialty/Specialties:_____

Board Certified ____ Yes / ____No Certifying Entity _____**Certification #** _____

Attach copy of current License and Board Certification(s)

Malpractice Carrier _____ **Policy #** _____

Malpractice $ Limit _____ **Expiry Date** _____

Do you support electronic billing ____ Yes / ____ No

Pay to Address (for Checks / Remittance Advice)

_____ _____ _____ _____
Street **City** **State** **Zip**

Billing Address (for Checks / Remittance Advice)

_____ _____ _____ _____
Street **City** **State** **Zip**

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GROUP AFFILIATIONS

Name _____ **NPI #** _____

TIN# _____ **Phone#:**_____

Street	City	State	Zip
_____	_____	_____	_____

Name _____ **NPI #** _____

TIN # _____ **Phone #** _____

Street	City	State	Zip
_____	_____	_____	_____

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS REQUIRED FOR BILLING PROVIDERS ONLY

I (we) hereby authorize Gainwell Technologies, acting as Fiscal Agent for the State of New Jersey, Division of Medical Assistance and Health Services, to initiate credit entries to my (our) checking account and the Depository bank indicated below, hereinafter called Depository, to credit the same to such account.

DEPOSITORY NAME _____ **BRANCH** _____

CITY _____ **STATE** _____ **ZIP**_____

BANK TRANSIT/ABA # _____**ACCOUNT #** _____
This authority is to remain in effect until the Fiscal Agent has received written notification from me (or either of us) of its termination in such time and in such manner as to afford the Fiscal Agent a reasonable opportunity to act on it.

BANK ACCOUNT NAME_____
(Print account name exactly as it appears on your statement)

NOTES:

1. To ensure accuracy of the bank account numbers, it is imperative that you attach a **BLANK, VOIDED CHECK** verifying the above bank ABA and account numbers.
2. The Authorization is specific to the NJ Medicaid FFS Payments. Additional billing information may be required by Medicaid/NJ FamilyCare managed care organizations.

PROVIDER CERTIFICATION:
The provider agrees to comply with all applicable State and federal law, rules and regulations in regard to the provision of the services rendered.

The provider agrees to indemnify the State of New Jersey and the appropriate Medicaid Program for the federal share of any payments for this claim in the event that the federal share of the payment on this claim is disallowed by the Centers for Medicare & Medicaid Services.

This is to certify that the foregoing information and any claim(s) for payment associated with this application are **true, accurate and complete**, and to acknowledge that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable federal or State laws and may lead to me being personally liable for any claims submitted to a federal or State payer along with penalties associated with such claims. I understand that payment and satisfaction of this claim will be from federal and State Funds, and that payment received will be considered payment in full. Furthermore, I agree not to institute or cause the initiation of collection activities, including, but not limited to, billing, balance billing and litigation, against beneficiaries, their family members, their representatives, or others on their behalf for the payment of claims, except as permitted by

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N.J.S.A. 30:4D-6.c., NJAC 10:74-8.7, or as otherwise permitted or required by State or federal statutes and regulations. Finally, I hereby certify that I am not currently debarred, excluded, revoked or suspended by HHS-OIG, or from the program for which I am enrolling, from the Medicare program, or from any other state Medicaid program. I also certify that my professional certification and/or license is not currently in a suspended (either temporarily or for a specific period of time) or revoked status, including surrenders deemed as a revocation in any jurisdiction as a result of, or relating to, an action initiated by a professional board or other oversight body. The Medicaid/NJ FamilyCare streamlined enrollment application process will remain in force for the duration of this public health emergency. Afterwards, continued Medicaid/NJ FamilyCare participation may require completion of a full application.

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

☐ **By checking this box, I certify that I have obtained the original signatures in this application, and will furnish them upon request by NJ DMAHS.**

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PROVIDER NAME: _____

PROVIDER AGREES:

1. To comply with all applicable State and federal laws, policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish the DMAHS, the Secretary of the U.S. Department of Health and Human Services, the Medicaid Fraud Control Unit of the Division of Criminal Justice, and the Medicaid Fraud Division within the Office of the State Comptroller with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To provide services to eligible beneficiaries without discrimination and to comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and to be aware that it is a punishable crime to make any false statement or representation of a material fact in order to receive any benefits or payment under the medical assistance program and CHIP. (The Department of Human Services is required by federal regulation to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended) See also N.J.S.A. 30:4D-17 for State false claim penalties;

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.107;

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c., NJAC 10:74-8.7,or otherwise permitted or required by State or federal Law.

The provider or DMAHS may, on 60 days written notice to the other party, terminate this Agreement without cause.

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

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This application is intended to allow a provider to participate in the fee-for-service NJ FamilyCare/Medicaid Program. Participation with any or all of our five managed care partners will require completing their contracting processes. Their contact information is outlined below.

NJ FamilyCare Health Plans Currently Under Contract and Providing Medicaid Managed Care Services in New Jersey

Aetna Better Health of New Jersey
3 Independence Way, Suite 400
Princeton, NJ 08540
Provider Services Phone Number: 1-855-232-3596

AMERIGROUP New Jersey, Inc.
101 Wood Avenue South, 8th Floor
Iselin, New Jersey 08830
Provider Relations Phone Number: 1-800-454-3730

Horizon NJ Health
1700 American Blvd.,
Pennington, NJ 08534
Provider Relations Phone Number: 1-800-682-9091

UnitedHealthcare Community Plan
333 Thornall St, 9th Floor
Edison, NJ 08837
Provider Service: 1-888-362-3368

WellCare
33 Washington Street, 1st Floor
Newark, NJ 07102
Provider Services: 1-888-453-2534

For additional detail regarding MCOs specific enrollment refer to the individual MCO Provider Quick Reference Guides at: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/hmo/index.html

Form submission methods:

Encrypted eMail (preferred)	By fax	By mail
njmmisproviderenrollment@gainwelltechnologies.com	609-584-1192 Attention: Gainwell Provider Enrollment	Gainwell Provider Enrollment Unit Attention: Reeshemah Trower PO Box 4804 Trenton, NJ 08650-4804

Please call 609-588-6036 if you have any questions about this application.

For Fiscal Agent Internal Use Only

Group Provider Name: _____

Doc Type: Enrollment Application Provider Type: _____ Provider Specialty: _____

Provider Number: _____