

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
GROUP PROVIDER ENROLLMENT FORM

Shaded Area for HP Enterprise Services use only

Provider Number

Link ID

1. Group Name _____

2. Business Name (if applicable) _____

3. Business Type Corporation LLC Partnership
 Franchise Other
(Attach supporting documentation)

Name Type _____

Census Tract _____

Cnty Code _____

Town Code _____

Location _____

4. Owner/Administrator, Managing Employee or Officer of Corporation Name **O**____ **A**____

5. FEIN _____

6. Service Location Address _____ City _____ State _____ Zip _____

Telephone () _____ Fax Number _____

7. Pay to Address _____ City _____ State _____ Zip _____

8. Mail to Address _____ City _____ State _____ Zip _____

Telephone () _____ Fax Number _____

9. Billing Service Address _____ City _____ State _____ Zip _____

Telephone () _____ Fax Number _____

10. Additional Practice Locations:

Street _____ City _____ State _____ Zip _____

Street _____ City _____ State _____ Zip _____

Street _____ City _____ State _____ Zip _____

11. Office Email Address _____ Contact Person _____

12. Are you currently or have you ever been a provider under another medical specialty with Medicaid? YES NO

Dates: (Active and Inactive) _____

Status: _____

If Yes: What is your Rhode Island Medicaid ID Number/s _____

13. Is this application due to a merger, buy out or take over?

YES NO

14. List any outstanding balance owed to Executive Office of Health and Human Services Medicaid program by previous provider?

15. List your Medical Specialty _____ (see attached document)

16. National Provider Identifier (NPI) Number/s _____

17. Taxonomy Number/s _____

18. Electronic Biller YES NO

19. Fiscal Year End Date _____

20. Enrollment effective date or date first served RI Medicaid client.

_____ (Effective date is mandatory)

21. Exclusions under 42 CFR and/or sections 1128B and 1932(d)(1) of the Social Security Act: Prohibits you from 1) knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, excluded, or has been convicted of a criminal offence related to that person's involvement in any Federal program, or 2) having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, excluded, or convicted of a criminal offence related to that person's involvement in any Federal program.

This applies to myself and/or the entity(s): YES NO

If Yes, Please List (a) Date of Issuance, (b) Duration, (c) Name and address of person:

22. Document information on any debarment, suspension, exclusion, or criminal offence from federal program?

I certify that the foregoing information is true, accurate, and complete with the understanding that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Signature of Provider, Senior Partner, Chief Corporate Officer, or Authorized Agent

Title

Date

Full Name (printed)

Please note: Only one signature is permitted and must be consistent on all enrollment documents.

