WVCHIP PROVIDER PRE-ENROLLMENT APPLICATION – QUESTIONS

√ 1. Are you a current WVCHIP Medical Home Provider or would you like to be a WVCHIP Medical Home Provider? ◯ Yes ◯ No

Family and General Practitioners, Internists, RHC/FQHC's, and Pediatricians can choose to be a Medical Home Provider. More information is available at www.chip.wv.gov

√ 2. If you are an out-of-state provider and are interested in continuing or starting participation with WVCHIP, are you willing to accept in-state rates for your services? ◯ Yes ◯ No

If YES, continue completing the application, if NO, please read below notification prior to completion of the application for additional information.

Waiver for Out-of-State Prior Authorization Option

WVCHIP has a blanket Prior Authorization on services provided outside the state of West Virginia. (Primary Care in bordering counties and all emergency services are excluded.) The process evaluates whether services provided out-of-state are available in-state within an area geographically accessible to the member. WVCHIP will waive this requirement when out-of-state providers agree to 1) accept in-state rates as payment in full and 2) not balance bill WVCHIP members for the difference between submitted charges for covered services and WVCHIP's fees. NOTE: Prior Authorization of some specialized services will still apply regardless of whether the services are provided in or out-of-state.) For more information on in-state rates, please email WVCHIPPROVIDER@outlook.com.

Out-of-state providers that wish to participate but do not wish to accept WVCHIP's in-state rates will need to contact WVCHIP at wvchip@wv.gov to negotiate rates for services provided to our members. Out-of-state prior authorization requirements will apply. Providers must also agree not to balance bill WVCHIP members.

WV MEDICAID and/or WVCHIP PROVIDER SIGNATURE AGREEMENT

Signature Authorization

The WV Medicaid and/or WVCHIP effective date of participation is determined after Molina Medicaid Solutions has completed the credentialing and approved the application for enrollment. You will be notified by letter of enrollment approval. If this application is being submitted for new enrollment, do not schedule Medicaid patient visits until notified of enrollment approval.

Submit the completed application within 60 days of the authorized official's signature below. Molina Provider Enrollment must receive the application before the 60 days expires Any delays of enrollment due to missing information required for submitting this application could require an updated application, or signature attesting to the validity and accuracy of current information submitted within this application.

The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business is the authorized signatory of this form. A delegated administrator may sign this form if it has been expressly indicated in writing on company letterhead signed by the authorized official on file or attached to this application.

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth therein. As of the date of signature, the information contained within this application is accurate and current.

1. *Legal Name of Provider's Business (please print):	2. *Taxpayer Identification Number (TIN):
3. *Authorized Official's Name (please print):	4. *Title:
5. *Authorized Official's Signature:	6. *Date:
7. *Contact Name & Phone Number:	8. *Contact Email Address:

WVCHIP PROVIDER ENROLLMENT AGREEMENT and SIGNATURE

www.wvmmis.com

A SEPARATE PROVIDER AGREEMENT MUST BE COMPLETED BY EACH RENDERING PROVIDER AND A REPRESENTATIVE OR AUTHORIZED DELEGATE FOR THE GROUP/FACILITY.

1. The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the West Virginia Children's Health Insurance Program (WVCHIP), including but not limited to Title XXI and Title XIX (Medicaid) of the Social Security Act, the Code of Federal Regulations, the West Virginia State Plan and any other laws, regulations related to healthcare providers.

2. The Provider certifies that the care, services and supplies for which the Provider bills WVCHIP have been furnished to eligible WVCHIP members and the amount listed will be due and no part has been paid by the WVCHIP member, member family, or other third-party payer. Provider understands that WVCHIP cannot and will not make payment (s) on any claim (s) where any portion of the claim is payable by another entity or person. To be eligible for WVCHIP, members cannot have any other group health insurance.

3. The provider agrees to accept the WVCHIP payment as payment in full and will not balance bill the member or member's family for the difference between the WVCHIP payment and the provider charge amount for the service.

4. The Provider assures WVCHIP that the Provider is an independent contractor and that neither the Provider nor any of the Provider's employees are employees of the Department/WVCHIP under this enrollment form and any subsequent amendments. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

5. The Provider agrees to comply with those Federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B-(4-88) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. The Provider shall provide for the compliance of any subcontractors with applicable Federal requirements and assurances. The Provider, as provided by 31 U.S.C. §1352 and 45 CFR§93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U. S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

6. The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C.§200d, et. seq.), the Age Discrimination Act of 1975 (42 U.S.C. §6101 et. seq.), the American with Disabilities Act of 1990 (42 U.S.C. §12101, et. seq.) and §504 of the Rehabilitation Act of 1973 (29 U.S.C. §794 and 45 CFR Part85).

7. The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid and/or WVCHIP program or any activity connected with the provision of Medicaid and/or WVCHIP services.

8. The Provider agrees to protect the confidentiality of recipient information pursuant to state and federal law specifically §1902 (a) (7) of the Social Security Act and 42 CFR §431.300 et. seq.

9. The Provider shall maintain records in accordance with federal and state regulations for a period of five (5) years or three (3) years after audits, with any and all exceptions having been declared resolved by the WV Department of Health and Human Resources. Said records shall fully demonstrate the extent, nature and medical necessity of services and items provided to WVCHIP members who support the fee or rate charged or payment sought for the service and items and which demonstrate compliance with all applicable requirements.

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10. The Provider shall make all records and documentation available upon request to the WV Department of Health and Human Resources, and/or the United States Department of Health and Human Services, the Fraud Control Unit, WVCHIP and any other authorized governmental entity under applicable laws, regulations and policies.

11. The Provider agrees to comply with the disclosure requirements as specified in 45 CFR part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and person convicted of crimes. Upon request, the Provider agrees to provide to the Department/WVCHIP, the U.S. Department of Health and Human Services the information requested in 42 in U.S.C. § 1396b (s) pertaining to limitation on certain physician referrals.

12. The Provider agrees to repay subject to due process and procedures the Department/WVCHIP the amount of any payment under the WVCHIP program to which to provider was not entitled, regardless of whether the incorrect payment was the result of Department/WVCHIP error or other cause.

13. The Provider agrees that all claims for services will be medically necessary to the health of the specific patient and were furnished personally by the Provider or an employee under his/her direction. The Provider agrees to comply with the provisions of 42 CFR §447.10. The Provider further certifies that all information listed on a claim for reimbursement from WVCHIP is true, accurate and complete. I understand that payment of any claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

14. This Enrollment may be canceled by either party at any time, with or without cause, upon no less than thirty (30) working days written notice.

15. The Provider acknowledges that this enrollment is effective for the category of services as stated herein or that a separate provider enrollment form or a separate provider agreement may be necessary for certain services. The Provider further certifies that all information listed on this and any application is true, accurate and complete.

16. The Provider agrees to notify WVCHIP, in writing, of any changes in the provider information.

I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.
ORIGINAL SIGNATURE(S) REQUIRED - MUST BE IN BLUE INK

_____
Provider Name (Please Print)

_____ _____
Provider Signature Date of Signature

DO NOT FAX APPLICATION

Mail application to:
Molina Medicaid Solutions
Provider Enrollment
P.O. Box 625
Charleston, WV 25322-0625