

# **INSTRUCTIONS FOR COMPLETING THE PROVIDER APPLICATION**

(ALL INFORMATION MUST BE PRINTED LEGIBLY OR TYPED)

## **CONTRACT**

- PAGE 1:            “**The Provider**” – means the individual provider **or** the organization/group.
- **Individual Provider** – print or type provider name on the first line, leave next line blank
  - **Organization or Group** – print or type organization or group name on the first line and the name of the person authorized to sign for the organization or group on the next line.
- I.            **PLEASE READ CAREFULLY AND NOTE** :
- The reimbursement rates
  - The Program is payor of **last** resort.
  - Acceptance as **payment in full** the amount reimbursed by the Program and/or the patient’s health insurance, if applicable, **and not** to seek additional payment from the patient except in the case of commercial insurance co-insurance amounts. Billing the patient for account balances except as described is a **violation** of this agreement.
- PAGE 2:            II.            **PLEASE READ CAREFULLY AND NOTE:**
- Termination requires 30 days notice in writing and notification of patients **prior** to rendering additional services of your withdrawal from the Program. This provides patients the opportunity to transfer to a participating provider.
  - Please obtain appropriate signature

## **DEMOGRAPHIC INFORMATION**

- PAGE 1:            **INDIVIDUAL PRACTICE** – Any individual M.D. or individual M.D. within a group practice when the group is not contracting with the Program.
- GROUP PRACTICE/ORGANIZATION** – Complete only when all physicians of a group are applying to participate. **Please provide a list of all individuals and ALL of their office locations.**
- BILLING ADDRESS** – PLEASE ATTACH A COPY OF THE W-9
- **Tax ID number** – This is the ID number used. If the tax ID is used by another organization (e.g., hospital, corporate pharmacy, etc.) a suffix must be added to the Tax ID number. This suffix identifies your organization separately for payment and **must** appear on all claims. The billing address must match exactly that which appears in Box 33 of the CMS 1500. **Any** changes must be reported **immediately** to the central office in order to prevent a delay in payment. **Please identify the Tax ID# as SSN or EIN.**
  - **Please provide a BLANK copy of a CMS 1500 with your billing name and address in Box 33 (OBTAIN FROM YOUR BILLING OFFICE).**
  - **Contact Person** – Please provide the name and telephone number of the person to contact in case of problems. This should be the office manager or billing supervisor.
  - **Medical Office** – Please provide a list of all offices locations and their respective contact persons. This information is helpful to our patients and providers.

PAGE 2:            **NPI NUMBER** – Please provide your National Provider Identifier number on the appropriate line.

**LICENSE NUMBERS** – Please provide copies of all applicable licenses. Your office will be asked to update this information periodically. If physicians, please attach a copy of each individual’s current medical license.

## **ATTACHMENTS:**

- PAGE 1:            Billing information for all providers except pharmacies
- PAGE 2:            Billing information for pharmacies only

*Provider Agreement for Participation in the  
Breast and Cervical Cancer Diagnosis and Treatment Program*

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**BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM**  
**Maryland State Department of Health and Mental Hygiene**  
**Family Health Administration**

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This agreement is entered into between the Maryland State Department of Health and Mental Hygiene (“the Department”) and \_\_\_\_\_ (“the Provider”) by \_\_\_\_\_, the Provider’s duly authorized representative (in the case of a group, institutional, or corporate provider), to provide covered services for breast and/or cervical cancer diagnosis and treatment to Program eligible individuals in accordance with COMAR 10.14.02. The provider is advised that the applicable regulations may differ significantly from those of other third-party payor programs.

**I. THE PROVIDER AGREES:**

- A. To comply with all applicable requirements or the Breast and Cervical Cancer Diagnosis and Treatment Program as well as any other applicable regulations, transmittals, and guidelines issued by the Department. The provider acknowledges his responsibility to become familiar with those requirements.
- B. To maintain adequate records which fully describe the nature and extent of all goods and services provided and rendered.
- C. To provide covered breast and/or cervical cancer diagnostic and/or treatment services for uninsured patients at the current Medical Assistance reimbursement rate or, if the provider is a hospital, at the current HSCRC rate.
- D. To provide breast and/or cervical cancer diagnostic and/or treatment services for insured patients at the rate approved by the patient’s health insurer. Patient co-payments are the responsibility of the patient except for Medicare recipients, for whom reimbursement of the patient contribution amount shall be made by the Program. Reimbursement for the outstanding deductible up to the allowed amount shall be made by the Program for all insured patients.
- E. That if the provider is a pharmacy, the Program shall reimburse the patient contribution amounts (deductible and co-payment) for insured patients.
- F. That if the provider is a home health agency, the Program shall reimburse the following: Maryland hospital based providers at the current HSCRC rate; and non-hospital based providers at the rate per visit set by Maryland Medicaid.
- G. That if the patient has insurance, to seek reimbursement from that source first. If reimbursement is made by both the Program and the insurer, the provider shall refund to the Department, within 60 days of receipt, the amount reimbursed by the Program or the insurer, whichever is less.
- H. To accept as payment in full the amount reimbursed by the Program and/or the patient’s health insurer for the service rendered and not seek additional payment from the patient except as stated in D. of this section.
- I. To accept responsibility for the accuracy of all claims submitted to the Program.
- J. To attest that all claims submitted under the provider number shall be for services rendered for breast and/or cervical cancer diagnosis and/or treatment.
- K. To assume liability for the procedures and/or services rendered.

*State of Maryland*  
**Provider Agreement for Participation in the  
Breast and Cervical Cancer Diagnosis and Treatment Program**  
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**II. THE DEPARTMENT AGREES:**

- A. To pay the provider for services for breast and/or cervical cancer diagnosis and/or treatment provided to uninsured or insured, low-income patients in accordance with all Program regulations by reference in the Code of Maryland regulations.
- B. To provide notice of changes in the Program regulations through publication in the *Maryland Register* in accordance with their publication schedule.

**III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:**

- A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this agreement by giving thirty (30) days notice in writing to the other party. The Provider shall notify patients, prior to rendering additional services, of withdrawal from the Program.
- B. That the effective date of this agreement shall be the date on which it is signed by the Provider. This agreement shall remain in effect until such time as it is terminated by either party pursuant to the terms of this agreement. Termination of this agreement shall not discharge the obligation of the Provider with respect to services or items furnished prior to termination, including retention of records and restitution of overpayments.
- C. That this agreement shall not be transferable or assignable.
- D. That payment shall be contingent upon the availability of funds per State Finance Procurement Article, §§7-234 and 7-235, annotated Code of Maryland.

_____ Provider Signature	_____ Date
_____ Provider Name (Please type or print)	

*[This agreement cannot be processed until all the information in the Provider Application Form (see attached) is completed and received by the Center for Cancer Surveillance and Control]*

**PLEASE RETURN PROVIDER AGREEMENT AND COMPLETED APPLICATION TO:**

*Center for Cancer Surveillance and Control  
Maryland Department of Health and Mental Hygiene  
Family Health Administration  
P.O. Box 13528  
Baltimore, Maryland 21203-2399*

For questions, please call (410) 767-6787.



*State of Maryland*  
**Provider Application for Breast and Cervical Cancer Diagnosis and Treatment Program**  
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**PROVIDER TYPE: (Check one)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> MD                 | <input type="checkbox"/> Home Health        | <input type="checkbox"/> Medical Item Supplier            |
| <input type="checkbox"/> Hospital           | <input type="checkbox"/> HMO                | <input type="checkbox"/> Medical Laboratory               |
| <input type="checkbox"/> Pharmacy           | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Free Standing Ambulatory Center  |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Nurse Anesthetist  | <input type="checkbox"/> Free Standing Radiology Facility |

**PHYSICIAN SPECIALTY: (Check as many as apply)**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Anesthesiology     | <input type="checkbox"/> Hematology        | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Psychiatry         |
| <input type="checkbox"/> Cardiovascular     | <input type="checkbox"/> Immunology        | <input type="checkbox"/> OB-GYN           | <input type="checkbox"/> Pulmonary Disease  |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Orthopedic       | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Family Practice    | <input type="checkbox"/> Medical Oncology  | <input type="checkbox"/> Otolaryngology   | <input type="checkbox"/> Radiology          |
| <input type="checkbox"/> Gastroenterology   | <input type="checkbox"/> Nephrology        | <input type="checkbox"/> Pathology        | <input type="checkbox"/> Surgery            |
| <input type="checkbox"/> General Practice   | <input type="checkbox"/> Neurology         | <input type="checkbox"/> Plastic Surgery  | <input type="checkbox"/> Urology            |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Thoracic          | <input type="checkbox"/> Vascular         | <input type="checkbox"/> Dermatology        |
| <input type="checkbox"/> Ophthalmology      | <input type="checkbox"/> GYN Oncology      | <input type="checkbox"/> Endocrinology    | <input type="checkbox"/> Cardiology         |
| <input type="checkbox"/> Breast Surgery     | <input type="checkbox"/> Other: _____      |   |   |

**NPI NUMBER:** \_\_\_\_\_  
 (INDIVIDUAL PROVIDER) (ORGANIZATION)

**LICENSE NUMBERS:** (Fill in license numbers as appropriate. A copy of the individual license or permit **MUST** be attached.)

_____ Hospital License Number	_____ Issue Date	_____ Expiration Date
_____ Physician License Number	_____ Issue Date	_____ Expiration Date
_____ Maryland State Laboratory Permit Number	_____ Issue Date	_____ Expiration Date
_____ CLIA Identification Number	_____ Issue Date	_____ Expiration Date
_____ Pharmacy License Number	_____ Issue Date	_____ Expiration Date
_____ NCPDP Number	_____ Medical Assistance Number	

**If there is more than one provider in this group or organization, please attach a list of all providers, their medical license numbers and their location(s).**

**PLEASE RETURN COMPLETED APPLICATION TO:**  
 Center for Cancer Surveillance and Control  
 Maryland Department of Health and Mental Hygiene  
 Family Health Administration  
 P.O. Box 13528  
 Baltimore, Maryland 21203-2399

*For questions, please call (410) 767-6787.*

FOR STATE USE ONLY:

Departmental Authorization \_\_\_\_\_

Date \_\_\_\_\_ Expiration Date \_\_\_\_\_