

STATE OF WYOMING EQUALITYCARE PROGRAM



Please Complete and Return to:

ACS
P.O. Box 667
Cheyenne, WY 82003
1-800-251-1268

For any further information on EqualityCare,
please visit our website at <http://wyequalitycare.acs-inc.com/>.

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Name and Business Organization Information (All applicants must complete)

1

Name and
Type of
Business
Practice

Practitioners and Practitioner Groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual practitioners must be enrolled.

If an individual wants payments made to a corporation or sole proprietorship (group), the group must be enrolled and have a group provider number. All claims must identify the group provider number as the billing provider on all claims. Individual practitioners must enroll using the name shown on their social security card. If payments for services are to be made to a group practice, or corporation, then the group, or corporation must enroll and obtain an EqualityCare provider number to be used for submitting claims as the billing provider. All individual practitioners who render services must be enrolled.

Individual's Last Name First Name Middle Initial Title/Degree

Legal business name (exactly as registered with the Internal Revenue Service)

Doing Business As (DBA) name (if applicable)

Social Security Number or Tax Identification Number

For Fiscal Agent Use Only

ACS Assigned Provider #

Wyoming Department of Health Approval

Effective Date

Approval Date

Address Information

2

Service
Location,
Address &
Phone
Information

Physical Location

All applicants must complete. Provide the street address of the location where services will be rendered. If services are provided at more than one location, identify the primary practice location.

Name

Street Address (must be street address)

City County State Zip

Telephone Number Fax Number

For Fiscal Agent Use Only

Two-digit County Location Code

Address Information (cont)

2

Service Location, Address & Phone Information

Payment Address (optional)

Payments (if any) made under the assigned provider number will be sent to this address if different from the service location address above. Complete only if different from above.

Name

Attn

Street Address, PO Box

City

State

Zip

Correspondence Address (optional)

Billing instructions are communicated through EqualityCare publications. If your publications are to be sent to a billing agent, you are responsible for obtaining information from the agent. Enrolled providers are responsible for reading and ensuring an appropriate response to information in EqualityCare publications.

Name

Attn

Street Address, PO Box

City

State

Zip

3

Other Registration Information

UPIN and DEA number

Applicants with Universal Provider Identification Number (UPIN) or Drug Enforcement Agency Number (DEA) must complete. Provide the requested information in the boxes provided.

UPIN ⇒

DEA Number ⇒

Provider Certification and Registration Information

4

Pharmacy Registration Information

Pharmacy Registration Information

Pharmacy applicants must complete. National Council on Prescription Drug Programs (NCPDP) number. (7-digit number) (Formerly National Association of Board Pharmacies (NABP) number)

Provide your NCPDP number in the box provided.

5

Begin Date

Desired Begin Date _____

Provider Taxonomy

6

Provider Taxonomy

All applicants must complete. From the list below, identify the provider taxonomy appropriate to the Wyoming Provider Enrollment Application. Check the box(es) in the far left column that applies to your Provider Taxonomy Code. You must complete a separate application for each provider taxonomy. If you do not find the appropriate provider taxonomy on the list below, you may not be eligible to enroll in a Federal/State Program at this time. Please call Provider Relations for assistance and further directions.

Taxonomy	Taxonomy Description	Licensure & Certification	Claim Types
Ambulance Services			
341600000X	Ambulance	License, Medicare Certification*	M, B
Audiology Services			
231H00000X	Audiologist	License	M, B
332S00000X	Hearing Aid Equipment	By Request	M
Chiropractic Services			
111N00000X	Chiropractor	License, Medicare Number, Medicare Crossover claims only	B
Dental Services			
1223G0001X	Dental, General Practice	License	D, M, B
122300000X	Dentist	License	D, M, B
1223X0400X	Orthodontics	License	D, M, B
1223P0221X	Pedodontics	License	D, M, B
1223P0300X	Periodontics	License	D, M, B
1223S0112X	Surgery, Oral & Maxillofacial	License	D, M, B
1223E0200X	Endodontist	License	D, M, B
DME/Orthotics & Prosthetics Services			
332B00000X	Durable Medical Equipment and Medical Supplies	Medicare Certification*	M, B
335E00000X	Prosthetic/Orthotic Supplier	Medicare Certification*	M, B
Home Health/Hospice Services			
251E00000X	Home Health	Out-of-State: Medicare Certification*, Aging Division Approval In-State: Medicare Certification* Medicaid Only Provider: License, Aging Division Approval	O, V
251G00000X	Hospice Care, Community Based	Medicare Certification*, Out-of-State: Aging Division Approval	O, V
Hospital Services			
282N00000X	General Acute Care Hospital	License, Medicare Certification*	I, O, X, V
282NR1301X	General Acute Care Hospital - Rural (Critical Access Hospital)	Medicare Certification*, Office of Medicaid Approval	O, V
275N00000X	Medicare Defined Swing Bed Unit	C & T Agreement, License, Out-of-State: Aging Division Approval	I, X
283Q00000X	Psychiatric Hospital	License, Medicare Certification*, Mental Health Division Approval	I, O, X, V
283X00000X	Rehabilitation Hospital	License, Medicare Certification*, CARF, Primary Care Services Approval	I
Laboratory Services			
291U00000X	Clinical Medical Laboratory	CLIA Certification	M, B

Taxonomy	Taxonomy Description	Licensure & Certification	Claim Types
<i>Mental Health Professional Services</i>			
103TC0700X	Clinical Psychologist	License, Mental Health Division Approval	M, B
261QM0801X	Mental Health - including Community Mental Health Center	Mental Health Division Approval	M, B, L
101YP2500X	Professional Counselor	License, Medicare Number, Medicare Crossovers only	B
261QR0405X	Rehabilitation, Substance Use Disorder (Case Management)	Substance Abuse Division Approval	M, B
<i>Nursing Facility Services</i>			
314000000X	Skilled Nursing Facility	License, Medicare Certification*, Out-of-State: Aging Division Approval	I, X, V, N
<i>Nurse Practitioners Services</i>			
367A00000X	Midwife, Certified Nurse	License	M, B
367500000X	Nurse Anesthetist, Certified Registered	License	M, B
363L00000X	Nurse Practitioner	License	M, B
363LA2200X	Nurse Practitioner, Adult Health	License	M, B
363LF0000X	Nurse Practitioner, Family Health	License	M, B
363LG0600X	Nurse Practitioner, Gerontology	License	M, B
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology	License	M, B
363LP0200X	Nurse Practitioner, Pediatrics	License	M, B
364SP0808X	Nurse Practitioner, Advanced Practice	License	M, B
<i>Pharmacy Services</i>			
333600000X	Pharmacy	License, NABP, POS Agreement	P
<i>Physician Services</i>			
200000000X	Allopathic/Osteopathic	N/A	N/A
207KA0200X	Allergy and Immunology, Allergy	License, DEA Number	M, B
207L00000X	Anesthesiology	License	M, B
207SG0201X	Clinical Genetics (M.D.)	License, DEA Number	M, B
207N00000X	Dermatology	License, DEA Number	M, B
2085R0202X	Diagnostic Radiology	License	M, B
207P00000X	Emergency Medicine	License, DEA Number	M, B
207Q00000X	Family Practice	License, DEA Number	M, B
207R00000X	Internal Medicine	License, DEA Number	M, B
207RC0000X	Internal Medicine, Cardiovascular Disease	License, DEA Number	M, B
207RE0101X	Internal Medicine, Endocrinology, Diabetes and Metabolism	License, DEA Number	M, B
207RG0100X	Internal Medicine, Gastroenterology	License, DEA Number	M, B
207RG0300X	Internal Medicine, Geriatric Medicine	License, DEA Number	M, B
207RX0202X	Internal Medicine, Medical Oncology	License, DEA Number	M, B
207RN0300X	Internal Medicine, Nephrology	License, DEA Number	M, B
207RP1001X	Internal Medicine, Pulmonary Disease	License, DEA Number	M, B
207RR0500X	Internal Medicine, Rheumatology	License, DEA Number	M, B
207T00000X	Neurological Surgery	License, DEA Number	M, B
204D00000X	Neuromusculoskeletal Medicine/OMM	License, DEA Number	M, B
207V00000X	Obstetrics and Gynecology	License, DEA Number	M, B

Taxonomy	Taxonomy Description	Licensure & Certification	Claim Types
207VG0400X	Obstetrics and Gynecology, Gynecology	License, DEA Number	M, B
Physician Services (cont)			
207VX0000X	Obstetrics and Gynecology, Obstetrics	License, DEA Number	M, B
207W00000X	Ophthalmology	License, DEA Number	M, B
207Y00000X	Otolaryngology	License, DEA Number	M, B
207ZP0105X	Pathology	License	M, B
2080N0001X	Pediatrics, Neonatal-Perinatal Medicine	License, DEA Number	M, B
208100000X	Physical Medicine and Rehabilitation	License, DEA Number	M, B
363A00000X	Physician Assistant	License, Medicare Number, Medicare Crossover claims only	B
208D00000X	Physician, General Practice	License, DEA Number	M, B
208000000X	Physician, Pediatrics	License, DEA Number	M, B
2083P0901X	Preventive Medicine, Public Health and General Preventive Medicine	License, DEA Number	M, B
2084N0400X	Psychiatry and Neurology, Neurology	License, DEA	M, B
2084P0800X	Psychiatry and Neurology, Psychiatry	License, DEA, Mental Health Division Approval	M, B
208600000X	Surgery, General	License, DEA Number	M, B
207X00000X	Surgery, Orthopedic	License, DEA Number	M, B
2086S0120X	Surgery, Pediatric	License, DEA Number	M, B
2082S0099X	Surgery, Plastic	License, DEA Number	M, B
208G00000X	Surgery, Thoracic	License, DEA Number	M, B
2086S0129X	Surgery, Vascular	License, DEA Number	M, B
208800000X	Urology	License, DEA Number	M, B
Podiatry Services			
213E00000X	Podiatrist	License, Medicare Number, Medicare Crossover claims only	B
Residential Treatment Centers			
323P00000X	Psychiatric Residential Treatment Facility	License, Medicare Certification*, Mental Health Division Approval	I, O, X
323P00000X	Psychiatric Residential Treatment Facility (RTC Mental Health Services)	License, JCAHO Certification, Mental Health Division Approval	M, B
322D00000X	Residential Treatment Facility for Emotionally Disturbed Children (RTC Therapy Services)	License, Mental Health Division Approval, certification	M, B
322D00000X	Residential Treatment Facility for Emotionally Disturbed Children (RTC)	License, Letter of Attestation or Medicare Certification*, Mental Health Division Approval	I, X
Specialty Clinics			
261QA1903X	Ambulatory Surgical Center	Medicare Certification*	M, B
261QE0700X	End-Stage Renal Disease (ESRD) Treatment	Medicare Certification*	O, V
261QF0400X	Federally Qualified Health Center	FQHC Certification, Office of Medicaid Approval	O, V, D
261QR0208X	Radiology, Mobile	Medicare Certification* (facilities must be certified as portable)	M, B
261QR0401X	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	License, Medicare Certification* Primary Care Services Approval	O, V
261QR1300X	Rural Health Center	Medicare Certification*, Office of Medicaid Approval	O, V
Therapy Services			
225X00000X	Occupational Therapist	License	M, B
225100000X	Physical Therapist	License	M, B

Taxonomy	Taxonomy Description	Licensure & Certification	Claim Types
Vision Services			
156FX1800X	Optician	License	M, B
152W00000X	Optometrist	License	M, B
Waiver Services			
251B00000X	Case Management	Division on Aging Approval, Developmental Disabilities Division Approval	W
251C00000X	Day Training, Developmentally Disabled Services	Division on Aging Approval, Developmental Disabilities Division Approval	W
*Medicare certification consists of a letter from Medicare or an EOMB that is no older than 180 days.			

M = Medical/HCFA-1500	B = Medicare Part B Crossovers	D = Dental
I = Inpatient	L = LTC Screening	N = Long Term Care/Nursing Facility
O = Outpatient	P = Pharmacy	T = Transportation
V = Outpatient Crossovers	W = Waiver	X = Inpatient Crossover

7

Mark the applicable type of business:

- | | |
|--|---|
| <input type="checkbox"/> Individual Practice | <input type="checkbox"/> Privately Owned |
| <input type="checkbox"/> Corporation/Professional Organization | <input type="checkbox"/> Group |
| <input type="checkbox"/> Government Entity | <input type="checkbox"/> Nonprofit Organization |

8

If you have previously billed Wyoming EqualityCare, please indicate the provider number you used.

Are you a member of a group practice? (Group practice means more than one physician or other practitioner billing under the same tax ID.)

YES NO

If yes, please enter the group number used.

9

Will you be billing for Health Check - Routine well-child screenings?

YES NO

Ownership Information (All applicants must complete)

10

Copy this page and complete for each person who has an ownership or control interest of 5% or more OR is an agent or managing employee in this provider entity.

A. Name (First, Middle, Last, Jr., Sr., MD., DO., etc.)		Date of Birth	
County/State/Country of Birth		Social Security #	WY EqualityCare #
Are you the spouse, parent, child or sibling of other persons who have an ownership or control interest or is an agent or managing employee in this provider entity? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, provide name(s) of person, relationship and indicate their percentage of ownership)			
B. Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? <input type="checkbox"/> No (Go to item C) <input type="checkbox"/> Yes If yes, fill in the following for each organization. Attach a copy of the organization's form IRS-P575 or, if not available, the W-9.			
Organization Legal Business Name	Employer ID No.	EqualityCare ID No.	
Organization Legal Business Name	Employer ID No.	EqualityCare ID No.	
Organization Legal Business Name	Employer ID No.	EqualityCare ID No.	
Organization Legal Business Name	Employer ID No.	EqualityCare ID No.	
Organization Legal Business Name	Employer ID No.	EqualityCare ID No.	
C. Parent/Joint Venture Information Is your organization a subsidiary company or joint venture? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES , fill in the following information about your parent company/joint business)			
Legal Business Name	Employer ID No.	EqualityCare ID No.	
Business Street Address Line 1			
Business Street Address Line 2			
City	County	State	Zip Code
Phone Number		Fax Number	

Definitions

Ownership Interest means equity in the capital, the stock or the profits of the provider.

Person with an ownership or control interest means a person, partnership, corporation or other entity that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust, not or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the provider or in an entity that has an indirect ownership interest in the provider.

Licensure

11

Licensure

Licensure

All applicants must complete. Using Section 5 above as a reference, complete the license information required for the provider taxonomy, and attach a copy of license(s).

License No.	License Authority/Board	Expiration Date

Additional Provider Participation Information

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Medicare Participation Information

Medicare Participation Information

All Medicare providers must complete. Complete the information requested below about Medicare Part B participation. To receive Federal/State Program payments for services provided to individuals who have Medicare Part B and Federal/State Program benefits, providers must accept assignment of their Medicare Part B claims.

Automatic crossover is an exchange of claim information between Medicare Part B and a Federal/State Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Federal/State Program. Federal/State Programs obtain crossover claim information from Wyoming Medicare Part B carriers and intermediaries. For automatic crossover to occur, providers must identify their Medicare numbers. If you wish to have assigned Medicare claims cross automatically to a Federal/State Program, please list your Medicare Part B numbers here. Individuals who are part of a group or clinic should only list their individual numbers, not the group's base number.

Medicare numbers for automatic crossover from Medicare Part B to Federal/State Programs.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

13

Provider Group and Billing Agent

Provider Group and Billing Agent

If you are a member of a group, enter the Practice(s) Name, Address, and Telephone Number. If you work for a hospital and they bill for you, enter the Hospital(s) Name, Address, and Telephone Number. Enter the date you became a member of the group practice or starting working for the hospital in MMDDYY format. If you do not belong to a group practice, leave these blocks blank. **Note:** If a group or hospital is billing for you, give them your EqualityCare provider number.

Group Provider's Name, Address, and Phone#	Effective Date	Shaded area for ACS use only. Assigned Group Number

13

Provider Group and Billing Agent

Provider Group and Billing Agent (cont)

If you contract with a billing agent to bill for you electronically, enter the Billing Agent's Name, Address, and Telephone Number. Enter the date the Agent started billing claims for you in MMDDYY format. If you do not have a billing agent, leave these blocks blank. The billing agent must enroll in the EqualityCare program and sign all the EqualityCare agreements before they can submit claims on your behalf.

Billing Agent's Name, Address, and Phone#	Effective Date	Shaded area for ACS use only. Billing Agent's Number
<hr/> <hr/> <hr/>	 	

14

CLIA Registration Information

CLIA – Fill in only if applicable

Applicants who provide laboratory-testing services must complete. Enter your CLIA registration number(s) in the boxes provided. **You MUST attach a photocopy of your CLIA certificate(s).** Attach additional pages if necessary.

15

Sanction Information

Sanction Information

All applicants must complete. Complete the information about any possible convictions that may have occurred in relation to EqualityCare/Medicare or any other Federal/State Programs. Providing such information will assist the Department of Health and Human Services and Office of Inspector General (OIG) in deciding what action, if any, should be taken on a provider's (your) application based on such convictions.

Please check the appropriate box and provide additional information if required:

Have you ever been convicted of a crime relating to EqualityCare/Medicare or any other Federal/State Program?

- Yes
- No

If yes, please explain and attach any applicable documentation. _____

Provider Enrollment Certification

I,

the undersigned, certify the following:

1. I have read the contents of the Wyoming Provider Enrollment Application and the information contained herein is true, correct and complete. If I become aware that any information in the Wyoming Provider Enrollment Application is not true, correct or complete, I agree to notify the Office of Medicaid or ACS of this fact immediately.
2. I authorize the Office of Medicaid or ACS to verify the information contained herein. I agree to notify the Office of Medicaid or ACS of any changes in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller will require a new enrollment.
3. I am familiar with and agree to abide by the State/Federal laws, regulations and program instructions that apply to my provider type. The State/Federal laws, regulations and program instructions are available through the Office of Medicaid. I understand that payment of a claim by State/Federal health care program is conditioned on the claim and the underlying transaction complying with such laws, regulations and program instructions (including the anti-kickback statute and the Stark law), and on a provider being in compliance with any applicable conditions of participation in any federal health care program.
4. Neither I, as an individual practitioner, nor any owner, director, officer or employee of the company or other organization on whose behalf I am signing this certification statement, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare/Medicaid or other State/Federal Program or debarred, suspended or excluded under any other federal agency or program, or otherwise is prohibited from providing services to Medicaid/Medicare or other State/Federal health care program beneficiaries.
5. I agree that any existing or future overpayment to me by state/federal health care program(s) may be recouped by the state/federal health care program(s) through withholding future payments.
6. I understand that only the billing number for the provider who performed the service or to whom benefits were reassigned under current State/Federal health care program regulations may be used when billing State/Federal health care program(s) for services.
7. I understand that if I do not submit claims for a total of 3 years, my provider number will be inactivated and I will have to enroll again.
8. I understand that any omission, misrepresentation or falsification of any information contained in the Wyoming Provider Enrollment Application or contained in any communication supplying information to any State/Federal health care program(s) to complete or clarify the Wyoming Provider Enrollment Application may be punishable by criminal, civil, or other administrative actions including revocation of State/Federal health care program(s) billing number(s), fines, penalties, damages, and/or imprisonment under Federal Law.
9. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by any State/Federal health care programs, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
10. I further certify that I am the individual practitioner who is applying for the billing number, or in the case of a business organization, I am an officer, chief executive officer, or general partner of the business organization that is applying for the State/Federal health care program(s) billing number.

Name & Title

Date

Signature

Name & Title of person completing form

Phone Number

WOLFS Form (All applicants must complete)

RETURN TO:
State Auditor's Office
Capitol Building, Room 114
Cheyenne, WY 82002
(307) 777-7831 Fax (307) 777-6983

State of Wyoming
REQUEST FOR TAXPAYER
IDENTIFICATION NUMBER & CERTIFICATION

WOLFS-109
revised 10/2003

PLEASE PRINT OR TYPE: Forms that are illegible or incomplete will not be processed.

PURPOSE OF THE FORM: The State of Wyoming is required to file an information return with the IRS, so a correct Taxpayer Identification Number (TIN) is required below.

IRS regulations provide the following: If you fail to furnish your correct TIN to a requestor, you may be subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. If you make a false statement with no reasonable basis that results in no backup withholding, you may be subject to a \$500 penalty. If you willfully falsify certifications or affirmations you may be subject to criminal penalties including fines and/or imprisonment.

A. OWNERSHIP TYPE THAT APPLIES TO YOU OR YOUR BUSINESS: (you must check only **one** ownership type below, and supply the applicable **SSN or EIN**)

- Individual SSN: _____
- Sole Proprietor (includes one-member Limited Liability Companies) SSN: _____ OR EIN: _____
- Partnership (includes Limited Liability Companies with 2 or more members) Corporation (Prof. Corp., S-Corp, etc.) Gov't. Entity
- Nonprofit Corp. Trust Other (be specific) _____ EIN: _____

B. ADDITIONAL INFORMATION: (required)

OFFICIAL TAX REPORTING NAME: _____

BUSINESS, TRADE OR "DBA" NAME (if different from above): _____

MAILING ADDRESS (Number, Street, and Apt. or PO Box): _____

City _____ State _____ Zip Code _____

PHONE NUMBER (include area code): _____ E-MAIL: _____

BUSINESS DESCRIPTION: _____

C. ELECTRONIC FUNDS TRANSFER PREFERENCE (check one):

I DO NOT desire payment by Electronic Funds Transfer (EFT). Sign certification below.

I DO desire payment by Electronic Funds Transfer (EFT). Check one of the options below, and then sign certification below.

NOTE: The State reserves the right to debit or reverse a credit made erroneously to an account without prior notification.

OPTION ONE: Attach a photocopy of a "voided check" or an actual voided check (Do not attach a "deposit slip", since deposit slips do not contain sufficient information for processing). STOP HERE, NO FURTHER ACTION IS REQUIRED.

OR

OPTION TWO: Have a representative from your financial institution complete all of the following required information.

ABA ROUTING NUMBER: _____

FINANCIAL INSTITUTION NAME: _____

ACCOUNT NUMBER: _____

FINANCIAL INSTITUTION STREET OR P.O. BOX ADDRESS: _____

FINANCIAL INSTITUTION CITY, STATE, ZIP: _____

ACCOUNT TYPE: (check one) C-CHECKING S-SAVINGS

SIGNATURE OF FINANCIAL INSTITUTION REPRESENTATIVE: _____

I CERTIFY UNDER PENALTY OF PERJURY THAT:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
- *2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

* You must cross out item number "2" above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

SIGNATURE: _____

DATE: _____

**INSTRUCTIONS FOR COMPLETING THE WOLFS-109,
Request for Taxpayer Identification Number & Certification, FORM
(The State of Wyoming's substitute for the IRS Form W-9)**

The State of Wyoming is required to file an information return with the Internal Revenue Service (IRS) and must get your correct Taxpayer Identification Number (TIN) to report, for example, income paid to you. The IRS uses the TIN for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return.

The Internal Revenue Service considers a Taxpayer Identification Number (TIN) as incorrect if either the name or number shown on an account does not match a name and number combination in their files or the files of the Social Security Administration (SSA).

The WOLFS-109, Request for Taxpayer Identification Number & Certification, form (is the State of Wyoming's substitute for the IRS Form W-9). The WOLFS-109 is used by the State of Wyoming for persons required to file information returns with the IRS to get the payee's correct TIN. Completion of the WOLFS-109, Request for Taxpayer Identification Number & Certification, form:

OWNERSHIP TYPE THAT APPLIES TO YOU OR YOUR BUSINESS: Vendors may check **only one** box.

NUMBER, OFFICIAL TAX REPORTING NAME and BUSINESS, TRADE OR "DBA" NAME:

The Taxpayer Identification Number (TIN) is always a 9-digit number and can be a Social Security Number (SSN) assigned to an individual by the Social Security Administration or an Employer Identification Number (EIN) assigned to a business and other entities by the Internal Revenue Service. Your name and TIN should be the same as used for tax filing purposes.

Individual

- I. For individuals, the TIN is generally a social security number (SSN).
- II. **OFFICIAL TAX REPORTING NAME** - enter the name exactly as it is shown on your social security card. If you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, "-" (hyphen) and your new last name.

Sole Proprietor - includes one-member Limited Liability Company (LLC)

- I. A sole proprietor must furnish his or her individual name and either his or her SSN or the EIN for his or her sole proprietorship. If you are a sole proprietor and you have an EIN, you may enter either you SSN or EIN. However, the IRS prefers that you use you SSN.
- II. If using a SSN:

OFFICIAL TAX REPORTING NAME - enter the name exactly as it is shown on your social security card.

BUSINESS, TRADE OR "DBA" NAME - you may enter your business, trade or "doing business as (DBA)" name.

- III. If using an EIN:

OFFICIAL TAX REPORTING NAME- enter the name as shown on required Federal tax documents.

BUSINESS, TRADE OR "DBA" NAME - you may enter your business, trade or "doing business as (DBA)" name.

Partnerships and Limited Liability Company (LLC) with two or more members

- I. Partnerships and if the owner of a LLC is a corporation, partnership, etc., enter the EIN.
- II. **OFFICIAL TAX REPORTING NAME** - enter the name of the corporation, partnership, etc. as shown on Federal tax documents.
- III. **BUSINESS, TRADE OR "DBA" NAME** - you may enter any business, trade or "doing business as (DBA)" name.

Corporations

- I. If you are a corporation enter the EIN of the business as shown on required Federal tax documents.
- II. **OFFICIAL TAX REPORTING NAME** - enter your business name as shown on required Federal tax documents.
- III. **BUSINESS, TRADE OR "DBA" NAME** - you may enter any business, trade or "doing business as (DBA)" name.

Other Entities

- I. If you are a public entity (such as a state or local government, school district), association, club, religious, charitable, trust, estate or educational organization enter the EIN of the organization as shown on required Federal tax documents.
- II. **OFFICIAL TAX REPORTING NAME** - enter your business name as shown on required Federal tax documents.
- III. **BUSINESS, TRADE OR "DBA" NAME** - you may enter additional organization names or "doing business as (DBA)" name.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Fund Transfer (EFT) is the preferred method of payment for all payees receiving payments from the State of Wyoming. EFT saves the State money and is more efficient for the payee.

EFT allows for payments to be credited to the payee's designated account electronically similar to an employee's direct deposit of payroll. Payments are more predictable, with no delays to the payee. Remittance information is transmitted to the vendor bank and is provided to vendors on their bank statements. This remittance information can also be accessed via the Internet at the State Auditor's web site <http://sao.state.wy.us/eft.htm>

Provider Agreement

STATE OF WYOMING
DEPARTMENT OF HEALTH, OFFICE OF MEDICAID
WYOMING MEDICAID/EQUALITYCARE PROGRAM

Revised 03/17/05



1. **Parties.** The parties to this Provider Agreement are the [Provider], whose name and address are delineated on page four (4) of this Agreement, and the Wyoming Department of Health, Office of Medicaid, whose address is 147 Hathaway Bldg. or 2300 Capitol Ave., Cheyenne, WY 82002.
2. **Purpose of Provider Agreement.** The purpose of this Provider Agreement is to ensure that the Provider who furnishes services to clients of EqualityCare and EqualityCare related programs (hereafter EqualityCare) bills and receives payment for such services in accordance with applicable law.
3. **Term of Provider Agreement and Required Approvals.** This Provider Agreement is effective when all parties have executed it and shall remain in effect until such time as the Provider Agreement is terminated by a party to the Provider Agreement. Unless terminated by the Office of Medicaid for cause, pursuant to Section 7.0 of this Agreement, a provider who wishes to terminate this Provider Agreement shall provide 30 days notice of termination.
4. **Payment.** The Office of Medicaid agrees to pay the Provider for services provided to Wyoming Medicaid/EqualityCare clients in accordance with Wyoming Medicaid Rules and applicable federal and state statutes and regulations. No payment shall be made before the last required signature is affixed to this Provider Agreement.
5. **Responsibilities of the Provider.** The Provider shall:
 - A. Comply with applicable state and federal law, including: the Social Security Act (42 USC 1936 et seq.); the Wyoming Medical Assistance and Service Act (Wyo. Stat. § 42-4-101 et seq.); the regulation of the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS) (42 CFR Subchapter C); and the Wyoming Department of Health (WDH) and Wyoming Medicaid Rules and policies.
 - B. Comply with applicable licensing and certification standards as contained in Wyoming statutes and regulations or applicable licensing and certification in the state where a service is provided.
 - C. Ensure that the charges for services or items provided to Wyoming EqualityCare clients shall not exceed the charges for comparable services or items provided to persons not eligible for Medicaid/EqualityCare.
 - D. Not submit claims for payment prior to provision of services.
 - E. Bill all third party payers as defined in WDH Rules and policies before submitting claims to the Office of Medicaid or its fiscal agent.
 - F. Accept as payment in full the amounts paid in accordance with Wyoming statutes and WDH and Wyoming Medicaid Rules and policies, and the Provider shall not seek additional payment from any source prohibited by law, including the client or any member of his or her family.
 - G. Not require prepayment by clients who present proper proof of EqualityCare eligibility, with the exception of services requiring co-payment as defined in Medicaid Rule or policy. This provision shall not apply to any service or item not covered by Wyoming's EqualityCare Program, if the client agrees in writing in advance to pay for such service or item.
 - H. File all claims in accordance with applicable federal and state laws and regulations and in accordance with the Wyoming Medicaid's Rules, policies and procedures.
 - I. Cooperate with the Office of Medicaid to recover any payment made under this Agreement which is later determined by the Office of Medicaid to have been in excess of that permitted by federal or state laws, regardless of whether the Provider or the Office of Medicaid caused the excess payment. The Provider further agrees to notify the Office of Medicaid in writing within 30 days after learning of any

excess payment.

- J. Retain all records necessary to fully disclose the extent of services or items provided to clients and all records necessary to document the claims submitted for EqualityCare reimbursement for such services or items. All such medical and financial records shall be retained by the Provider for 6 years beyond the end of the fiscal year in which payment for services was rendered, except that if any litigation, claim, audit or other action involving the records initiated before the expiration of the 6th year, the records shall be retained until the completion of the action.

Upon request, the Provider shall make on-site access to and/or copies of EqualityCare client records and information available to WDH or its authorized representatives, including HHS, the Comptroller General of the United States, the Attorney General of the State of Wyoming, Office of Medicaid, the Wyoming Medicaid Fraud Control Unit (MFCU), or any of their duly authorized representatives.

- K. Safeguard the use and disclosure of information concerning applications for or clients of Medicaid/EqualityCare services in accordance with applicable federal and state statutes and regulations.
- L. Submit, within thirty-five (35) days after the date of request by the Office of Medicaid, MFCU, and/or HHS, full and complete information as to ownership, business transactions and criminal activity in accordance with 42 CFR 455 Subpart B.
- M. Provide the Office of Medicaid with advance notice in accordance with Wyoming Medicaid Rule, of any change or proposed change in: name; ownership; licensure; certification, or registration status; type of service or area of specialty; additions, deletions or replacement in group membership; mailing addresses; and participation in Wyoming's EqualityCare program. A change in the Provider's ownership or organization shall not relieve the Provider of its obligations under this Provider Agreement, and all terms and conditions of this Provider Agreement shall apply to the new ownership or organization.
- N. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMOs specified in 42 CFR 489, Subpart I, and in 42 CFR 417.436(d).

6. **Special Provisions.** The Provider explicitly understands that:

- A. EqualityCare reimbursement is from state and federal funds and that any falsification of claims, statements or documents, or any concealment of material fact is a violation of state and federal laws, and any person who falsifies or conceals a material fact may be subject to criminal prosecution.
- B. The Provider is responsible for all EqualityCare claims submitted to the Office of Medicaid seeking reimbursement for services provided to a client, regardless of whether the claim is submitted by the provider's employee, sub-contractor, vendor or business agent.
- C. The Provider's participation in the Wyoming EqualityCare program may be sanctioned or terminated pursuant to the Rules of the Office of Medicaid, and the exclusive remedy for any dispute arising between Provider and WDH shall be pursuant to Wyoming Medicaid Rules.

7. **General Provisions.**

- A. **Applicable Law/Venue.** The construction, interpretation and enforcement of this Provider Agreement shall be governed by the laws of the State of Wyoming. The Courts of the State of Wyoming shall have jurisdiction over this Provider Agreement and the parties, and venue shall be the First Judicial District, Laramie County, Wyoming.
- B. **Assignment/Provider Agreement Not Used as Collateral.** Neither party shall assign or otherwise transfer any of the rights or delegate any of the duties set forth in the agreement without the prior written consent of the other party. The Provider shall not use this Provider Agreement, or any portion thereof, for collateral for any financial obligation.

- C. **Assumption of Risk.** The Provider shall be responsible for any EqualityCare claim submitted by the Provider and denied because of the Provider's failure to comply with State or Federal requirements. The Office of Medicaid shall notify the Provider of any State or Federal determination of noncompliance.
- D. **Audit/Access to Records.** The Office of Medicaid, the MFCU, HHS, and any of their representatives shall have access to any books, documents, papers, and records of the Provider which are pertinent to this Provider Agreement. The Provider shall, immediately upon receiving written instruction from the Office of Medicaid, provide to independent auditor, accountant, or accounting firm, all books, documents, papers and records of the Provider which are pertinent to this Provider Agreement. The Provider shall cooperate fully with any such independent auditor, accountant, or accounting firm, during the entire course of any audit authorized by the Office of Medicaid, the MFCU, or HHS.
- E. **Availability of Funds.** Each payment obligation of the Office of Medicaid is conditioned upon the availability of funds which are appropriated or allocated for the payment of this obligation. If funds are not allocated and available for the continuance of the services performed by the Provider, the Provider Agreement may be terminated by the Office of Medicaid at the end of the period for which the funds are available, or the Office of Medicaid may suspend payments to the Provider. The Office of Medicaid shall notify the Provider at the earliest possible time of the services which will or may be affected by a shortage of funds. At the earliest possible time means at least 60 days in advance. No penalty shall accrue to the Office of Medicaid in the event this provision is exercised, and the Office of Medicaid shall not be obligated or liable for any future payments due or for any damages as a result of termination under this section.
- F. **Compliance with Laws.** The Provider shall keep informed of and comply with all applicable Federal, State and local laws and regulations in the performance of this Provider Agreement.
- G. **Entirety of Provider Agreement.** This Provider Agreement represents the entire and integrated Provider Agreement between the parties.
- H. **Indemnification.** Provider agrees to defend and hold harmless the Office of Medicaid, the Department of Health and the State of Wyoming from any and all claims, lawsuits, losses and liability arising out of the Provider's failure to perform any of the Provider's duties and obligations hereunder or in connection with the negligent performance of the Provider's duties or obligations including but not limited to any claims, lawsuits, losses or liability arising out of malpractice on the part of the Provider.
- I. **Independent Contractor.** The Provider shall function as an independent contractor for the purposes of this Provider Agreement, and shall not be considered an employee of the State of Wyoming for any purpose. The Provider shall assume sole responsibility for any debts or liabilities that may be incurred by the Provider in fulfilling the terms of this Provider Agreement, and shall be solely responsible for the payment of all Federal, State and local taxes which may accrue because of this Provider Agreement. Nothing in this Provider Agreement shall be interpreted as authorizing the Provider or its agents and/or employees to act as an agent or representative for or on behalf of the State of Wyoming or the Office of Medicaid, or to incur any obligation of any kind on the behalf of the State of Wyoming or the Office of Medicaid. The Provider agrees that no health/hospitalization benefits, workers' compensation and/or similar benefits available to State of Wyoming Employees will inure to the benefit of the Provider or the Provider's agents and/or employees as a result of this Provider Agreement.
- J. **Kickbacks.**
- i. The Provider certifies and warrants that no gratuities, kickbacks or contingency fees were paid in connection with this Provider Agreement, nor were any fees, commissions, gifts, or other considerations made contingent upon the signing of this Provider Agreement.
 - ii. No staff member of the Provider shall engage in any contract or activity which would constitute a conflict of interest as related to this Provider Agreement.

- K. **Nondiscrimination and Americans with Disabilities Act.** The Provider shall not discriminate against any individual on the grounds of sex, race, color, religion, national origin, age or disability in connection with the Provider's performance under this Provider Agreement. The Provider shall comply with the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105 et seq.), and the Americans with Disabilities Act (ADA), 42 USC § 12101 et seq.
- L. **Notices.** All notices arising out of, or from, the provisions of this Provider Agreement shall be in writing and given to the parties at the address provided under this Provider Agreement, either by regular mail, facsimile, or delivery in person or as specified in applicable rule.
- M. **Sovereign Immunity.** The State of Wyoming and the Office of Medicaid do not waive sovereign immunity entering into this Provider Agreement, and specifically retain immunity and all defenses available to them as sovereigns pursuant to Wyo. Stat. § 1-39-104(a) and all other state law.
- N. **Taxes.** The Provider shall pay all taxes and other such amounts required by Federal, State and local law, including but not limited to, federal and social security taxes, workers' compensations, unemployment insurance and sales taxes.
- O. **Termination of Provider Agreement.** This Provider Agreement may be terminated immediately for cause if the Provider fails to perform in accordance with, or comply with, the terms of this Provider Agreement.
- P. **Waiver.** The waiver of any breach of any term or condition of this Provider Agreement shall not be deemed a waiver of any prior or subsequent breach.

8. **Signatures.** In witness thereof, the parties to this Provider Agreement either personally or through their duly authorized representatives, have executed this Provider Agreement on the days and dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of all four pages of this Provider Agreement and that the information furnished is true, accurate, and complete. ***Any alterations made to this document, or any additions or changes, handwritten or typed, to the text of this document shall void the document.***

Name of Provider

Street	City	State	Zip Code
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Authorized Signature and Title	Date
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Department of Health, Office of Medicaid



 Iris Oleske, Wyoming State Medicaid Agent

5/02/2001

 Date

Attorney General's Office Approval as to Form



 Joe A. Baca, Senior Assistant Attorney General

5/2/01

 Date

Return to:
 ACS
 P.O. Box 667
 Cheyenne, WY 82003-0667

Point of Sale Agreement (ONLY Pharmacy Providers must complete this section)

Point of Sale Agreement

THIS AGREEMENT made and entered into on this _____ day of _____, 20____, by and between the Office of Medicaid of the Wyoming Department of Health, hereinafter called the "Department," acting in its own right as the Agency responsible for administering Federal/State Programs and _____ hereinafter called "Provider."

WITNESSETH:

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the parties agree as follows:

1. The Department shall allow the Provider to submit claims to ACS through Point of Sale (P.O.S.).
2. The Provider agrees to pay a P.O.S. processing fee of \$.15 per transaction. A transaction is defined as any claim adjudicated by the P.O.S. system whether paid or denied. The processing fee will be deducted from the Provider's weekly check and will appear on the Remittance Advice (RA) as a gross adjustment credit.
3. The Provider shall safeguard Federal/State Programs against abuse in its utilization of claims entry through P.O.S.
4. The Provider shall correctly enter the claims data, monitor the data, and certify that the data is correct.
5. The Provider shall allow the Department access to claims data and assure that the transmission of claims data is restricted to authorized personnel so as to preclude erroneous payments by the Department's Fiscal Agent resulting from carelessness or fraud.
6. At the time of transmission of claims, the Provider shall have on file applicable source data in accordance with existing program requirements, i.e., charge data.
7. The Provider shall allow the Office of Medicaid or any of its designees and representatives to review and copy all records, including source documents data which relate to information entered for Federal/State Programs.
8. The Provider shall abide by all Federal and State statutes, rules, regulations, and manuals governing Federal/State Programs and those conditions as set out in the Medical Assistance Provider Agreement entered into previously.

Authorized Provider's Signature

Date