INSTITUTIONAL
MEDICAID PROVIDER AGREEMENT

The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:

(1) Discrimination. The parties agree that the Agency for Health Care Administration (agency) may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of sex, handicap, race, color, or national origin, other insurance, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(2) Quality of Service. The provider agrees that services or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with the agency. The services or goods must have been actually provided to eligible Medicaid recipients by the provider prior to submitting the claim.

(3) Compliance. The provider agrees to comply fully with all state and federal laws, rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by the agency, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts.

(4) Term and signatures. The parties agree that this is a voluntary agreement between the agency and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. Provided that all requirements for enrollment have been met, this agreement shall remain in effect for three (3) years from the effective date of the provider's eligibility for initial enrollment unless otherwise terminated. With respect to reenrolling providers, the agreement shall remain in effect for three (3) years from either the date the most recent agreement expires or the date the provider signs the renewal agreement, which ever date is earlier, unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no agency signature is required to make this agreement valid and enforceable.

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of signing of the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional, occupational, facility or other license pertinent to the services or goods being provided, as required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records the agency requires and determines are relevant to the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of five (5) years to satisfy all necessary inquiries by the agency.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Send, at the provider's expense, all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and other information pertaining to services or goods billed to the Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records to the Attorney General, the Federal Government, and the authorized agents of each of these entities.

(f) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person and comply with all other state and federal requirements in this regard.

(g) Report and refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program within ninety (90) days of receipt.

(h) Be liable for and indemnify, defend, and hold the agency harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient to the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation.

(i) Provide proof of liability insurance at the option of the agency and maintain such insurance in effect for any period during which services of goods are furnished to Medicaid recipients.

(j) Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except, and only to the extent the agency permits or requires, co-payments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. The Medicaid payment-in-full policy does not apply to services or goods provided to a recipient if the services or goods are not covered by the Medicaid program. This includes situations in which the provider's Medicare coinsurance claims are denied in accordance with Medicaid policy.

(k) Comply with all of the requirements of Section 6032 (Employee Education About False Claims Recovery) of the Deficit Reduction Act of 2005, if the provider receives or earns five million dollars or greater annually under the State plan.

(l) Submit, within thirty five (35) days of the date on a request by the Secretary or the Medicaid agency, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five (5) year period ending on the date of the request.

(m) Employ only individuals who may legally work in the United States, either U.S. citizens or foreign citizens who are authorized to work in the U.S, in compliance with the Immigration Reform and Control Act of 1986 which prohibits employers from knowingly hiring illegal workers.

(n) Utilize the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system to verify the employment eligibility of all persons employed by the provider during the term of this Contract to perform employment duties within Florida and all persons (including subcontractors) assigned by the provider to perform work pursuant to this Contract. The provider shall include this provision in all subcontracts it enters into for the performance of work under this Contract.

(o) Attest that all statements and information furnished by the prospective provider before signing the provider agreement shall be true and complete. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the option of the agency and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(p) Agree to notify the agency of any changes to the information furnished on the Florida Medicaid Provider Enrollment Application, including but not limited to changes of address, tax identification number, group affiliation, or depository bank account. The provider shall report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to five (5) percent or more in the provider to the agency in writing within thirty (30) days after the change occurs. For a hospital licensed under chapter 395, F.S., or a nursing home licensed under part II of chapter 400, F.S., a principal of the provider is one who meets the definition of a controlling interest under s. 408.803, F.S.

(q) Agree to notify the agency within five (5) business days after suspension or disenrollment from Medicare. Failure to notify may result in sanctions imposed pursuant s. 409.908 (24) and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

(r) Search the List of Excluded Individuals/Entities (LEIE), located at http://www.oig.hhs.gov/fraud/exclusions.asp, and the Agency's final order database, located at http://apps.ahca.myflorida.com/dm_web, monthly to determine whether any employee or contractor has been excluded. Providers will notify the Agency immediately any exclusion information discovered. Civil monetary penalties may be imposed against Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

(6) Agency Responsibilities. The agency shall:

(a) Make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim.
(b) Not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable to error of the agency in the determination of eligibility of a recipient.

(7) Change of Ownership. A Medicaid provider agreement may be revoked, at the option of the agency, due to a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) If the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the agency Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(b) If there is a change of ownership, the transferor remains liable for all outstanding overpayments, administrativefines, and any other moneys owed to the agency before the effective date of the change. The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179, F.S.

(c) At least sixty (60) days before the anticipated date of the change of ownership, the transferor must notify the agency of the intended change and the transferee must submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee are jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change.

(d) As used in this subsection, the term:

(1.) "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs the provider.

(2.) "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

(8) Termination for Convenience. This agreement may be terminated without cause upon thirty (30) days written notice by either party.

(9) Interpretation. When interpreting this agreement, it shall be neither construed against either party nor considered which party prepared the agreement.

(10) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida. Both parties concur that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. Any legal action involving this agreement will be brought in the appropriate court in Leon County, Florida, and the parties submit to exclusive venue and personal jurisdiction in that court.

(11) Amendment. This agreement, application and supporting documents constitute the full and entire agreement and understanding between the parties with respect to their relationship. No amendment is effective unless it is in writing and signed by each party.

(12) Severability. If one or more of the provisions contained in this agreement or application shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired.

(13) Agreement Retention. The parties agree that the agency may only retain the signature page of this agreement, and that a copy of this standard provider agreement will be maintained by the Director of Medicaid, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

(14) Funding. This contract is contingent upon the availability of funds.

(15) Assignability. The parties agree that neither may assign their rights under this agreement without the express written consent of the other.

A chief executive officer (CEO), president, or administrator may sign this agreement in lieu of all principals. Failure to sign the agreement will make the agreement and provider number voidable by the agency.

The signatory hereto represents and warrants that they have read the agreement, understand it, and are authorized to execute it on behalf of their respective principals. This agreement becomes null and void upon transfer of assets; change of ownership; or upon discovery by the agency of the submission of a materially incomplete, misleading or false provider application unless subsequently ratified or approved by the agency.

IN WITNESS WHEREOF, the undersigned representative has caused this agreement to be duly executed under the penalties of perjury and now affirms that the foregoing is true and correct.

(legibly print name of signatory)	Title	Signature	Date

Please Complete The Following Information:

Provider's Name: _____

DBA Name: _____

Tax Identification Number: _____

National Provider Identifier _____

Florida Medicaid Identification Number: _____

(For new applicants, the Medicaid ID will be entered by the fiscal agent upon approval of the application.)

Taxonomy Code: *(Optional)* _____

Effective Date of This Agreement: _____

Termination Date of This Agreement: _____

Florida Medicaid
Out-of-State Provider Application Form

Out-of-state providers must submit the following documents to Florida Medicaid with this application:

- *Florida Medicaid Electronic Funds Transfer (EFT) Authorization Agreement with voided check or bank letter,*
- *Completed claim form with supporting documentation of emergency services or care, emergency transportation, or prior authorized services, and one of the following:*
  - *Copy of facility license and a Florida Medicaid Institutional Provider Agreement, or*
  - *Copy of professional license and a Non-Institutional Provider Agreement, as appropriate.*

Fields marked with an asterisk (*) are required.
Fields marked with a carat (^), complete as applicable.
Forms and guides are available on the Medicaid Public Web Portal at www.mymedicaid-florida.com.
Taxonomies and Specialties by Provider Type can be obtained from the Provider Enrollment Forms page at www.mymedicaid-florida.com.

IDENTIFYING INFORMATION*

Taxonomies and Specialties by Provider Type can be obtained from the Provider Enrollment Forms page at www.mymedicaid-florida.com.

Provider Type*	Specialty Type*	*Taxonomy^*

Business or Last Name*

First Name^	Middle Initial^	Jr., Sr., etc.^

Doing Business As (D/B/A)^

Tax ID Type*	Tax ID*	Medicaid ID* *(state of operation)*	Medicare ID^	
❑ SSN ❑ FEIN				
NPI Type*	**NPI***	**Taxonomy***	**ZIP***	**+4^**
❑ IND ❑ ORG				

All electronic and paper claims must include the NPI, Taxonomy, and ZIP (+4), as entered above.

ADDRESSES*

Service Address*

Street Address Line 1* *(Not a P.O. or Drop Box)*

Street Address Line 2^

City*	State*	ZIP Code*	+ 4^

Telephone Number* *(with Area Code)*	Fax Number^	County*

E-mail Address*

Payment Address*

Address Line 1*			
Address Line 2^			
City*	State*	ZIP Code*	+ 4^

General Correspondence Address*

Address Line 1*			
Address Line 2^			
City*	State*	ZIP Code*	+ 4^

Home or Corporate Office Address*

Address Line 1*			
Address Line 2^			
City*	State*	ZIP Code*	+ 4^

SECTION 8: APPLICANT CERTIFICATION*

"I understand that, under Section 409.920, Florida Statutes, to knowingly submit false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider is a felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete.

I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information on my provider file, including but not limited to, a change of address, group affiliation, ownership or control interest, officers, directors, managing employee, tax identification number, or EFT bank account.

By signing this document, I am accepting the terms of the Medicaid Provider Agreement on file with Medicaid under the Medicaid ID disclosed in this document as applicable and binding on this new enrollment."

Authorized Signature*	
Printed Name of Authorized Signer*	Signature Date*

Mail completed form and all required attachments to:

DXC Technology
PO Box 7070
Tallahassee FL 32314-7070