

For Fiscal Agent Internal Use Only

Provider Name: _____
Doc Type: _____ Provider Type: _____ Provider Specialty: _____
NPI Number: _____ Social Security No.: _____



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

21st Century Cures Act Application for NJ FamilyCare Health Plan Providers

Legal Name: _____ DBA Name: _____

Date of Birth: _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Contact Name: _____ Contact Phone #: _____

Email Address: _____ Fax Number: _____

Type of Service: _____ SS #: _____ Tax ID: _____

Taxonomy Code: _____ (if available)

IF APPLICABLE, APPLICANTS MUST REPORT THE FOLLOWING INFORMATION

NPI Number: _____

Medicaid Provider No.: _____ State: _____

Medicare Provider No.: _____ Lab-CLIA No.: _____

Medical Professional License No.: _____ State of Licensure: _____

Federal DEA Registration No.: _____

Certification No.: _____ Type: _____ Certifying Entity: _____

State of Certification: _____

NJDCA Home Improvement Registration No.: _____

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You must attach a copy of all current License(s), Registration(s) and Board Certification(s) and complete the conviction/exclusion information and the provider certification on Page 4

Applicants completing this application are under no obligation to accept NJ FamilyCare (NJFC) fee-for-service (FFS) beneficiaries into their professional practice.

In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title.

Applicants approved as 21st Century Cures Act providers are not authorized to bill or receive NJFC FFS reimbursement from the State of New Jersey. However, providers may submit a full FFS application to receive such authorization if they so choose.

21st Century Cures Act providers are required to comply with all applicable State and federal laws, rules and regulations in regard to providing a healthcare service(s) to a NJFC beneficiary.

Final Adverse Actions /Convictions

The section below defines the convictions and final adverse actions that must be reported in this application regardless of whether any records were expunged or any appeals are pending.

Convictions:

1. Within the last 10 years preceding this application for enrollment or revalidation of enrollment, conviction for a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare or NJFC program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

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3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction under Federal or State law relating to the interference with or obstruction of any investigation of any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

1. Any revocation or suspension of a license by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare Identification Number.
5. Any Medicare revocation of any Medicare Identification Number.

Have you, under any current or former name or business identity, ever had any final adverse legal action(s) listed above under **Convictions, Exclusions, Revocations, or Suspensions** in this application, imposed against you? Yes _____ No _____

If yes, on a separate sheet of paper report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the final adverse legal action documentation and resolution.

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Provider's Certification:

Do you, under any current or former business identity, have uncollected debt, are or have been subject to payment suspension under a Federal health care program, or have had your billing privileges denied or revoked?

Yes _____ No _____ (If YES, attach a detailed explanation)

Have you, under any current or former business identity, have a current or former affiliation (directly or indirectly) with a provider of medical or other items or services or supplies, that has uncollected debt, has been or is subject to payment suspension under a Federal health care program, or has had its billing privileges denied or revoked?

Yes _____ No _____ (If YES, attach a detailed explanation)

I certify that the foregoing information provided in this application is true, accurate and complete and I also acknowledge that I understand that providing any false statement, or false document, or concealing any material facts may subject me to penalties and/or prosecution under applicable federal or state laws.

Also, by signing this application, I consent to a civil and criminal background check by DMAHS and/or by the Medicaid Fraud Division of the Office of the State Comptroller. I understand that if the results of this background check are unsatisfactory, the Division of Medical Assistance and Health Services may refuse an applicant's participation in the NJFC FFS program and the applicant's provider contract with the health plan may be terminated.

_____ Provider's Signature Original Signature Required - No Stamps	_____ Print Name	_____ Date
_____ Signature of Person Completing Form	_____ Print Name	_____ Date

Thank you for taking the time to enroll as a 21st Century Cures Act provider in the NJFC program as required by Federal regulations. Please mail the signed application with required documentation to:

Gainwell Technologies Provider Enrollment
P.O. Box 4804
Trenton, NJ 08650

You can also fax the completed application with credentials to: 609-584-1192.

If you have any questions, Gainwell Technologies Provider Enrollment can be reached at 609-588-6036.