Required Forms to Establish a Rural Health Clinic

June 4, 2013

Alice Makela Boykin CPC

Are you in a designated area

- Guy Nevins
  Department of Public Health
  Division of Provider Services
  201 Monroe Street, Suite 710
  Montgomery, Alabama 36104
  (334)206-5191

- **David P. Glass**
- Director, Georgia Primary Care Office
- State Office of Rural Health
- Georgia Department of Community Health
- 502 South Seventh Street
- Cordele, GA 31015-1443
- 229-401-3094

CMS - 29

Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0074

REQUEST TO ESTABLISH ELIGIBILITY TO PARTICIPATE IN THE HEALTH INSURANCE FOR THE AGED AND DISABLED PROGRAM TO PROVIDE RURAL HEALTH CLINIC SERVICES

Each rural health clinic site providing rural health clinic services and desiring to establish eligibility in the health insurance program should complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Administration district office.

PROVIDER NO. (RH1)

STATE/COUNTY (RH2) (RH2)

STATE REGION (RH3) (RH3)

I. IDENTIFYING INFORMATION (TO BE COMPLETED FOR EACH CLINIC SITE)

NAME OF CLINIC	STREET ADDRESS	
CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. (*Including Area Code*) (RH4)

NAME AND ADDRESS OF CLINIC OWNER(S) (RH5)

II. MEDICAL DIRECTION

III. CLINIC PERSONNEL (FULL TIME EQUIVALENTS)

(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)

IV. TYPE OF CONTROL (check one) (RH10)

	A. INDIVIDUAL	B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT
1. PROFIT	☐	☐	☐	STATE 3. ☐ LOCAL 4. ☐ FEDERAL 5. ☐
2. NON-PROFIT	☐	☐	☐	

If the rural health clinic site is part of an existing Medicare provider, indicate the provider number_____ (RH11)

V. FEDERAL SUPPORT

Is this clinic site receiving support from a Federal Program to provide health services in a medically underserved area or in an area with a shortage of primary care health manpower? ☐ YES ☐ NO (RH12)

TITLE OF FEDERAL PROGRAM: _____ (RH13)

Is this clinic participating in the Physician Extender Experiment Program (Section 222)? ☐ YES ☐ NO (RH14)

I certify that this application is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. This information will not be released to any persons or organizations outside the official administrative channels unless the undersigned individual specifically requests in writing that such disclosures be made. (Privacy Act of 1974 Public Law 93-579.)

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE (RH15)

Form CMS-29 (05/78)

CMS-1561A

Health Insurance Benefits Agreement (2 copies)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFITS AGREEMENT

(Agreement with Rural Health Clinic Pursuant to
Section 1861(aa)(2)(K)(ii) of the Social Security Act)

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act,

_____
(Insert name of clinic)

hereafter referred to as the Rural Health Clinic, hereby agrees:

(A) to maintain compliance with the conditions for certification set forth in part 491 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services any failure to do so;

(B) not to charge the beneficiary or any other person for items and services for which the beneficiary is entitled to have payment made under the provisions of part 405 of chapter IV, title 42 of the Code of Federal Regulations (or for which the beneficiary would have been entitled if the Rural Health Clinic had filed a request for payment in accordance with §410.165 of chapter IV), except for any deductible or coinsurance amounts for which the beneficiary is liable under §405.2410;

(C) to refund as promptly as possible any money incorrectly collected from a beneficiary or from someone on his or her behalf;

(D) to accept beneficiaries for care and treatment without limitations, except as it may impose on all other persons;

(E) to accept any additional provisions that the Secretary finds necessary or desirable for the efficient and effective administration of the Medicare program.

This agreement, upon submission by the Rural Health Clinic and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Rural Health Clinic and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Rural Health Clinic services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated.

In the event of a transfer of ownership, the agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for Rural Health Clinic by:	Accepted for the Secretary of Health and Human Services by:
NAME (SIGNATURE)	NAME (SIGNATURE)
TITLE	TITLE
DATE	DATE

HHS-690

Assurance of Compliance

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

OCR – Civil Rights Information for Medicare Certification

You will only need to submit this form if you are going to be a provider based RHC owned by a hospital.

Request Forms

- Guy Nevins
  Department of Public Health
  Division of Provider Services
  201 Monroe Street, Suite 710
  Montgomery, Alabama 36104
  (334)206-5191
  Email: Guy.Nevins@adph.state.al.us

Request Forms

Kris A. Adams, Manager, Applications and Waivers
State of Georgia, Department of Community Health Healthcare Facility Regulation Division
2 Peachtree St; Suite 31.318
Atlanta, Ga 30303
Ofc: 404-657-1511

- Once you have completed the CMS-29, CMS-1561A, and HHS-690 forms, they should be mailed to Mr. Guy Nevins at the Alabama Department of Public Health (at same address they were requested from).

CMS-855A

- CMS-855A is the Medicare application for RHC that has to be submitted to Cahaba GBA
- CMS-855A form can be downloaded from CMS website at www.cms.gov under Medicare – Provider Enrollment Certification – CMS Forms

CMS-855A

Be sure that you are using the new version of the CMS-855A that is dated 07/11. Effective November 1, 2011, CMS requires this new version be submitted.

Provider-Based Attestation Statement

- If you are owned by a hospital and are seeking approval as a provider-based RHC, you must submit the Provider-Based Attestation Statement when you submit the CMS-855A to Cahaba GBA

Provider-Based Attestation Statement

This Provider-Based Attestation Statement can be retrieved from Cahaba GBA's website under Part A, Enrollment, Provider-Based Status Determinations.

www.cahabagba.com

CMS-855A Application Fee

For year 2013 there is an application fee of $532.00. The provider must pay the application fee electronically through Pay.gov either via credit card, debit card, or electronic check. Providers are strongly encouraged to submit with

Application Fee (Cont.)

their CMS-855A application a copy of the Pay.gov receipt of payment. This may enable the Medicare contractor to more quickly verify that payment has been made.

CMS-855A Address for Alabama and Georgia

PAAR Provider Enrollment
P.O. Box 1537
Birmingham, AL 35201-1537

Completing the CMS-855A

- Section 1A = Reason for Application. Check "*You are a new enrollee in Medicare.*"
- Section 1B = Check all that apply

  Identifying Information
  Adverse Legal Actions/Convictions
  Practice Location Information
  Ownership Interest (Organizations)
  Ownership Interest (Individuals)

Section 1B (Cont.)

Chain Home Office Information
Billing Agency Information
Special Requirements for Home Health Agencies
Authorized Official(s)
Delegated Official(s) (Optional)

Completing Form (cont.)

Section 2 A-1. – Type of Provider will be *"Rural Health Clinic"*

Section 2 A-2, 2-3 and 2-4 "Leave blank"

Completing Form (cont.)

Section 2B-1, Identifying Information

* Legal Business Name
* Type of Organization Structure
* Tax Identification Number
* Incorporation Date and State
* Other Name (example: d/b/a)
* Check “Proprietary” or “Non-profit”
* Check Yes or No if part of Indian Health Service

Completing Form (cont.)

Section 2B-2, check: "State License Not Applicable" and "Certification Not Applicable"

Section 2C – Correspondence Address

Section 2D – Accreditation, check "no"

Section 3 – Adverse Legal History, check appropriate "yes" or "no"

Completing Form (cont.)

Section 4A – *Practice Location Inform*ation

You will check "Add" block and put in the date the practice originally started.

Complete all requested information. Medicare identification number will be "pending". Be sure to add NPI that will be assigned to RHC. Also be sure to add CLIA number.

Completing Form (cont.)

Section 4B – *Where Remittances Sent*

Be sure to check "Add" and use same date as previously"

Check which Special Payments address you want your remittances/notices sent.

Section 4C – Complete if you store Patients' Medical Records offsite.

Completing Form (cont.)

Section 5: Ownership Interest And/Or Managing Control for ORGANIZATONS

Complete this section if the RHC is not owned by individuals, but an organization.

Completing Form (cont.)

Section 6: Ownership Interest And/Or Managing Control (INDIVIDUALS)

You must complete this section for everyone who has ownership in the practice. Also must have at least one Managing Employee listed.

Completing Form (cont.)

Section 6A. Check "Add" box and enter the date the practice started.

It is best not of enter Medicare and NPI for the individual. Mainly, because they do not tie these individuals back using Medicare ID#.

Completing Form (cont.)

Section 6B. Be sure to check appropriate box for Adverse Legal Action

Completing Form (cont.)

Section 7. Only check this section if your practice is part of a Chain Organization.

Section 8. Complete this section if you will be using an Outside Billing Agency.

Skip Sections 9, 10, 11, and 12

Completing Form (cont.)

Section 13. Contact Person – This should be the person that is completing the form. Cahaba GBA will contact this person for any additional information or corrections that need to be made to the CMS-855A application.

Completing Form (cont.)

Section 15. Check "Add" box and enter date the practice started.

Enter information for Authorized Official Signature. *(This person must be listed in Section 6 in order to be able to sign.)*

You can have up to 2 signatures, but only 1 is required.

Completing Form (cont.)

Section 16. – Delegated Official(s)

This section is optional, but if no one is listed here, the authorized official will be the only person who can make changes and/or updates to the provider's status in the Medicare program. This person must also be listed in Section 6.

Completing Form (cont.)

Section 17. Supporting Documents

Check all that are appropriate and submit the required documents.

(You must submit a CMS-588 (Electronic Funds Transfer Form) with the CMS-855A.)

Documents

- Copy of Business License (if required)
- Copy of CLIA Certificate
- Copy of NPI Notification
- Written confirmation from the IRS confirming your Tax Identification Number (that matches your legal business name).

Documents (cont.)

- Copy of Articles of Incorporation (if corporation or LLC)
- Copy of W-2 for Managing Employee listed in Section 6
- If post office box number is used, you will need a copy of the current payment receipt from the post office

Documents (cont.)

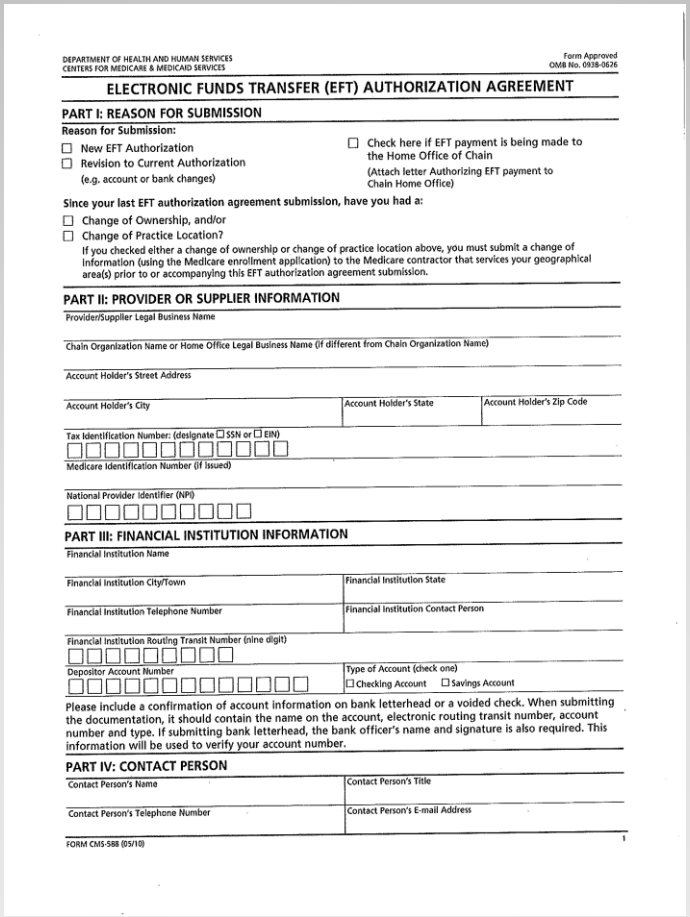
- Letter from the Bank verifying the routing and account number listed on the CMS-588 (EFT) form; OR an original check marked “Void”

Documents (cont.)

- If there is a loan at the bank in the name of the practice, you will need a letter from the bank stating "*the bank has agreed to waive its right of offset for Medicare receivables".* If there is NOT a loan at the bank, you will need a letter on the practice's letterhead stating *"that there is not a loan at the bank".*

- Also, be sure to include your payment receipt for the $532.00 application fee that you had to pay online at CMS's pay.gov website.

CMS-588 (EFT)



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- ☐ New EFT Authorization
- ☐ Revision to Current Authorization
  (e.g. account or bank changes)
- ☐ Check here if EFT payment is being made to the Home Office of Chain
  (Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- ☐ Change of Ownership, and/or
- ☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip Code

Tax Identification Number: (designate ☐ SSN or ☐ EIN)
☐☐☐☐☐☐☐☐☐

Medicare Identification Number (if issued)

National Provider Identifier (NPI)
☐☐☐☐☐☐☐☐☐☐

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)
☐☐☐☐☐☐☐☐☐

Depositor Account Number	Type of Account (check one)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

CMS-588, page 2

PART V: AUTHORIZATION

I hereby authorize the Centers for Medicare & Medicaid Services (CMS) to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account. CMS may assign its rights and obligations under this agreement to CMS' designated fee-for-service contractor. CMS may change its designated contractor at CMS' discretion.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CMS has received written notification from me of its termination in such time and such manner as to afford CMS and the Financial Institution a reasonable opportunity to act on it. CMS will continue to send the direct deposit to the Financial Institution indicated above until notified by me that I wish to change the Financial Institution receiving the direct deposit. If my Financial Institution information changes, I agree to submit to CMS an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	Date

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

DO NOT MAIL THIS FORM TO THIS ADDRESS.
MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.

CMS-588 (EFT)

- Part l – check New EFT Authorization
- Part ll – Provider Information - Fill in appropriate information. Put "*pending*" for Medicare ID#

CMS-588 (cont.)

- Part lll – Financial Institutional Information. Fill in apropriate banking informaiton
- Part lV – Contact Person – This is usually the person you indicated as “Managing Employee” (ex: Office Manager)

CMS-588 (cont.)

- Part V – Authorization – This should be the person that was designated as Authorized Signature on the CMS-855A.

Where to mail CMS-855A

- Alabama Part A Provider Enrollment
  Provider Audit and Reimbursement
  PO Box 1537
  Birmingham, AL 35201-1537

- Cahaba GBA will process your CMS-855A application request (usually within 60 days) and send approval letters back to you and your state Department of Public Health to Guy Nevins or Kris Adams Manager Applications and Waivers State of Georgia

- Once you have received the approval for the CMS-855A, you are ready to go to next step of requesting your RHC survey inspection.

- Guy Nevins
  Department of Public Health
  Division of Provider Services
  201 Monroe Street, Suite 710
  Montgomery, Alabama 36104
  (334)206-5191

Kris A. Adams, Manager, Applications and Waivers
State of Georgia, Department of Community Health
Healthcare Facility Regulation Division
2 Peachtree St; Suite 31.318
Atlanta, Ga 30303
Ofc: 404-657-1511
kadams@dch.ga.gov

While you are waiting:

- You need to be preparing your office for DHEC inspection.
- Make sure it is clean, neat and orderly and no clutter.
- No expired drugs or supplies.
- Prepare your Policy and Procedure Manual

- Thank you for you time if you have any question please feel free to get in touch with me. software.com

- **Alice Makela Boykin CPC**
- 803-236-2873
- alice@ams-software.com

- ***Rural Health Care Matters***