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**MAINE INTEGRATED HEALTH MANAGEMENT SOLUTION  
SERVICE LOCATIONS  
PROVIDER MAINTENANCE FORM (MIHMS\_MF\_0007)**

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The purpose of this form is to make modifications to a paper enrollment application. This form is to update any information regarding service locations.

Complete this form if you need to do any of the following:

- Add one or more new service locations
- Remove one or more existing service locations
- Update the information on file for one or more existing service locations

If modifications need to be made to owner(s) or board member(s) refer to Maine Integrated Health Management Solution OWNERS & BOARDS Provider Maintenance Form MIHMS\_MF\_0006.

If modifications need to be made to rendering provider(s) refer to Maine Integrated Health Management Solution RENDERING PROVIDERS Provider Maintenance Form MIHMS\_MF\_0008.

Please print or type all information so that it is legible. Use only blue or black ink. Do not use pencil.

Failure to provide accurate, complete information could result in delayed processing of your application and/or incorrect claim reimbursement.

Note that an asterisk (\*) following a question or field label in this form indicates required information.

If you are not changing service location information for your enrollment or have otherwise received this form in error, contact the MaineCare Provider Enrollment Unit at 1-866-690-5585.

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**SECTION 1. IDENTIFYING INFORMATION**

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1. What is your NPI or API? \*

\_\_\_\_\_

2. What is your tax ID? \*

Note: Supply at least one of the following numbers. You may provide both.

FEIN \_\_\_\_\_  SSN \_\_\_\_\_

3. Name \*

Note: For individuals, supply the name in this field in the format LastName, FirstName. For groups, supply the name in this field in the format Group Name. For facilities, agencies, or organizations, supply the name in this field in the format FAO Name. Ensure the name is spelled correctly.

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## SECTION 2. SERVICE LOCATION(S)

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Make as many copies of this Section (pages 2-15) as needed to document all service locations.

**Are you adding, removing, or updating information for a service location?**

- Adding a service location
- Removing an existing service location
- Updating information for an existing service location

If you are adding a service location that is licensed or certified for multiple provider type/specialty pairs and two or more of them are practiced at a single service location, you must complete Part B of this Section once for each provider type/specialty pair. Before you begin, make as many copies of those pages as needed to document all provider type/specialty pairs.

### Part A. Basic Location Information

Supply the following information for your service location. If providing services in the patient's home, you should indicate your office location. Questions 5-11 are requested for the MaineCare provider directory and are mandatory for providers participating in the Primary Care Case Management (PCCM) program. In-State and Border State providers may participate in PCCM. Border providers are those providers located in New Hampshire within 15 miles (24 km) of the Maine-New Hampshire border.

If you are adding a new service location and providing services in the patient's home, indicate the office location, not the addresses of your patients or clients.

#### 1. Service Location Name and Number \*

If you are enrolling with multiple service locations, each location must have a unique identifier. For this enrollment, it is requested that you provide both a unique name and a unique number for each service location.

For the service location name, provide a designator that will help you easily identify this service location later, such as "Main Street office" or "Augusta location".

If you are updating or removing an existing service location, supply the name of the service location

Supply the service location name in the following field:

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For the service location number, designate a 3-digit number, beginning with 001 for your first (or primary) location and continuing sequentially (002, 003, and so on) for subsequent locations. Supply the service location number in the following field:

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#### 2. Current Medicaid IDs \*

List all of the Medicaid IDs currently assigned to this service location. Separate the IDs with commas.

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**3. Physical Address \***

Is this address the same as the pay-to/W-9 address specified in the original paper application?

- Yes—skip to #4.       No—complete the following fields. You cannot specify a post office box for this address.

Address 1 \* \_\_\_\_\_

Address 2 \_\_\_\_\_

ZIP or Postal Code \* \_\_\_\_\_

City \* \_\_\_\_\_

County \* \_\_\_\_\_

State or Province \* \_\_\_\_\_

Country \* \_\_\_\_\_

Phone Number \* \_\_\_\_\_

Fax Number \_\_\_\_\_

If located in the State of New Hampshire, is this physical address within 15 miles (24km) of the Maine-New Hampshire border?

- Yes       No

**4. Mailing Address \***

Is this address the same as the pay-to/W-9 address specified in the original paper application?

- Yes—skip to #5.       No—complete the following fields.

Address 1 \* \_\_\_\_\_

Address 2 \_\_\_\_\_

ZIP or Postal Code \* \_\_\_\_\_

City \* \_\_\_\_\_

County \* \_\_\_\_\_

State or Province \* \_\_\_\_\_

Country \* \_\_\_\_\_

**5. Additional Languages Spoken**

If you, your colleagues, or other staff members at this service location speak one or more languages in addition to English, check the boxes next to the appropriate languages. The choices are listed on the enrollment form.

This information is requested for the MaineCare Provider Directory. It is mandatory that providers participating in the Primary Care Case Management (PCCM) program complete this item.

In the boxes below, mark all languages spoken by the staff of the service location.

- |                                            |                                        |                                        |                                        |
|--------------------------------------------|----------------------------------------|----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Acholi            | <input type="checkbox"/> English       | <input type="checkbox"/> Korean        | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Afrikaans         | <input type="checkbox"/> Estonian      | <input type="checkbox"/> Laotian       | <input type="checkbox"/> Sindi         |
| <input type="checkbox"/> Albanian          | <input type="checkbox"/> Ewe           | <input type="checkbox"/> Latvian       | <input type="checkbox"/> Singalese     |
| <input type="checkbox"/> Amharic           | <input type="checkbox"/> Farsi         | <input type="checkbox"/> Lebonese      | <input type="checkbox"/> Slovak        |
| <input type="checkbox"/> Ampango           | <input type="checkbox"/> Filipino      | <input type="checkbox"/> Lithuanian    | <input type="checkbox"/> Somali        |
| <input type="checkbox"/> Apache            | <input type="checkbox"/> Finnish       | <input type="checkbox"/> Macedonian    | <input type="checkbox"/> South Indian  |
| <input type="checkbox"/> Arabic            | <input type="checkbox"/> French        | <input type="checkbox"/> Malagasy      | <input type="checkbox"/> Spanish       |
| <input type="checkbox"/> Armenian          | <input type="checkbox"/> Gaelic        | <input type="checkbox"/> Malayalam     | <input type="checkbox"/> Srilankan     |
| <input type="checkbox"/> Assyrian          | <input type="checkbox"/> German        | <input type="checkbox"/> Maltese       | <input type="checkbox"/> Sudanese      |
| <input type="checkbox"/> Bengali           | <input type="checkbox"/> Greek         | <input type="checkbox"/> Mandarin      | <input type="checkbox"/> Swahili       |
| <input type="checkbox"/> Beti              | <input type="checkbox"/> Guarani       | <input type="checkbox"/> Marathi       | <input type="checkbox"/> Swedish       |
| <input type="checkbox"/> Bohemian          | <input type="checkbox"/> Gujarti       | <input type="checkbox"/> Meley         | <input type="checkbox"/> Tagalog       |
| <input type="checkbox"/> Bosnian           | <input type="checkbox"/> Haitian       | <input type="checkbox"/> Micmac        | <input type="checkbox"/> Taiwanese     |
| <input type="checkbox"/> Bulgarian         | <input type="checkbox"/> Hawaiian      | <input type="checkbox"/> Mien          | <input type="checkbox"/> Talan         |
| <input type="checkbox"/> Bunjabi           | <input type="checkbox"/> Hebrew        | <input type="checkbox"/> Neur          | <input type="checkbox"/> Tamali        |
| <input type="checkbox"/> Burmese           | <input type="checkbox"/> Hindi         | <input type="checkbox"/> Never         | <input type="checkbox"/> Tamil         |
| <input type="checkbox"/> Byelorussian      | <input type="checkbox"/> Hindustani    | <input type="checkbox"/> Nigerian      | <input type="checkbox"/> Telugu        |
| <input type="checkbox"/> Cambodian         | <input type="checkbox"/> Hmong         | <input type="checkbox"/> Norwegian     | <input type="checkbox"/> Thai          |
| <input type="checkbox"/> Cantonese         | <input type="checkbox"/> Hungarian     | <input type="checkbox"/> Pakistan      | <input type="checkbox"/> Turkish       |
| <input type="checkbox"/> Caribbean English | <input type="checkbox"/> Ibo           | <input type="checkbox"/> Pashto        | <input type="checkbox"/> Twi           |
| <input type="checkbox"/> Chamarro          | <input type="checkbox"/> Iceland       | <input type="checkbox"/> Passamaquoddy | <input type="checkbox"/> Ukranian      |
| <input type="checkbox"/> Chinese           | <input type="checkbox"/> Ilocana       | <input type="checkbox"/> Persian       | <input type="checkbox"/> Unknown       |
| <input type="checkbox"/> Circasian         | <input type="checkbox"/> Indian (East) | <input type="checkbox"/> Polish        | <input type="checkbox"/> Urdu          |
| <input type="checkbox"/> Croatian          | <input type="checkbox"/> Indonesian    | <input type="checkbox"/> Portuguese    | <input type="checkbox"/> Uzbek         |
| <input type="checkbox"/> Czech             | <input type="checkbox"/> Isujarati     | <input type="checkbox"/> Punjabi       | <input type="checkbox"/> Vietnamese    |
| <input type="checkbox"/> Danish            | <input type="checkbox"/> Italian       | <input type="checkbox"/> Romanian      | <input type="checkbox"/> Visayan       |
| <input type="checkbox"/> Dari              | <input type="checkbox"/> Japanese      | <input type="checkbox"/> Russian       | <input type="checkbox"/> Yiddish       |
| <input type="checkbox"/> Dinka             | <input type="checkbox"/> Kannada       | <input type="checkbox"/> Samoan        | <input type="checkbox"/> Yoruba        |
| <input type="checkbox"/> Dutch             | <input type="checkbox"/> Karachi       | <input type="checkbox"/> Serbian       | <input type="checkbox"/> Yugoslavian   |
| <input type="checkbox"/> Egyptian          | <input type="checkbox"/> Khmer         | <input type="checkbox"/> Serbo-Croati  | <input type="checkbox"/> Zairean       |
|                                            | <input type="checkbox"/> Kiswahili     | <input type="checkbox"/> Shan          |                                        |
|                                            | <input type="checkbox"/> Konkani       | <input type="checkbox"/> Shanghai      |                                        |

All questions on this page are required for PCCM participating providers. For providers not participating in the PCCM program, the questions on this page are optional. All responses will be included in the MaineCare Provider Directory.

**6. Is this service location accessible to persons with disabilities?**

Yes  No

**7. Is this service location accepting new patients?**

Yes  No

**8. What are the minimum and maximum acceptable ages of patients that receive services at this location?**

Minimum age: \_\_\_\_\_ years                      Maximum age: \_\_\_\_\_ years  
 (For infants, use 0 years. For the maximum age, the greatest allowed value is 112 years.)

**9. Is there a gender restriction for patients that receive services at this location?**

- No restriction
- Female patients only
- Male patients only

**10. Office Hours**

For days when services are unavailable, check the box next to Closed. For days when services are available, indicate the times at which this location opens and closes. Be sure to indicate a.m. or p.m. for each specified time. (Noon is 12:00 p.m. and midnight is 12:00 a.m.)

Monday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Tuesday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Wednesday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Thursday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Friday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Saturday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.
Sunday	<input type="checkbox"/> Closed	_____	<input type="checkbox"/> a.m.	to	_____	<input type="checkbox"/> a.m.
			<input type="checkbox"/> p.m.			<input type="checkbox"/> p.m.

**Part B. Provider Type and Specialties**

Note: If the service location that you are enrolling is licensed or certified for multiple specialties, you must provide a copy of this Part (pages 6-11) for each specialty. As applicable, complete the following licensure and certification information.

For a list of acceptable provider type and specialty values, refer to the appropriate Provider Enrollment Guide as follows:

- Enrollment Guide for In-State Individual Providers (EG-0001)
- Enrollment Guide for In-State Provider Groups (EG-0002)
- Enrollment Guide for In-State Facilities, Agencies, and Organizations (EG-0003)
- Enrollment Guide for Out-of-State Providers (EG-0004)
- Enrollment Guide for Non-Medicaid Providers (EG-0005)

**1. Provider Type \***

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**2. Specialty \***

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Is this the provider's primary specialty?     Yes    No

Begin Date:\* \_\_\_\_\_                      End Date: \_\_\_\_\_

**3. Specialized Questions**

- a. Are laboratory services offered in this office/facility? (If yes, you must also provide information in #7 below.)  
 Yes    No
- b. Do you have prescribing/dispensing privileges? (If yes, you must also provide information in #8 below.)  
 Yes    No
- c. Do you plan to provide, or are you currently providing prevention services for adults (age 21 and over)?  
 Yes    No
- d. Do you plan to provide, or are you currently providing Prevention, Health Promotion and Optional Treatment Services for members under 21 (formerly EPSDT)?  
 Yes    No
- e. Are you a licensed Hearing Aid Dealer?  
 Yes    No
- f. Do you provide wheelchair van services?  
 Yes    No
- g. Are you a specialized brain injury provider?  
 Yes    No
- h. Are you a provider for elderly, incapacitated, or dependent adults?  
 Yes    No

- i. Are you a provider of community based mental health services that owns or operates a residential treatment facility for persons with a primary diagnosis of mental illness?  
 Yes  No
- j. Are you a provider serving members with Developmental Disabilities exclusively?  
 Yes  No
- k. Will you be providing comprehensive targeted case management services to MaineCare members under Section 13 of the MaineCare Benefits Manual?  
 Yes  No  
 If Yes, What population will you be providing case management services to:  
 Children Involved with Protective Services  
 Adults Involved with Protective Services  
 Children with Developmental Disabilities  
 Adults with Developmental Disabilities  
 Children with Behavioral Health Disorders  
 Children with Chronic Medical Care Needs  
 Adults with Substance Abuse Disorders  
 Adults with HIV  
 Members Experiencing Homelessness  
 None
- l. Do you employ a certified Orthotist?  
 Yes  No
- m. Do you employ a certified Prosthetist?  
 Yes  No
- n. Are you providing services to Department of Corrections members?  
 Yes  No
- o. Under which model do you provide home support?  
 Home Support provided by an Agency:  Yes (number of members served: \_\_\_\_\_)  No  
 Shared Living Arrangement:  Yes  No  
 Family Center Support Model:  Yes (number of members served: \_\_\_\_\_)  No  
 Independent Living Model:  Yes  No
- p. If applicable, indicate the catchment area you are servicing:  
 Region 1: Aroostook County; Danforth in Washington County; and Patten in Penobscot County  
 Region 2: Hancock County including Isle au Haut; and Washington County excluding Danforth  
 Region 3: Penobscot County excluding Patten; and Piscataquis County  
 Region 4: Kennebec County and Somerset County  
 Region 5: Knox County; Lincoln County; Sagadahoc County; Waldo County; and Brunswick and Harpswell in Cumberland County  
 Region 6: Cumberland County  
 Region 7 Androscoggin County; Franklin County; and Oxford County excluding Porter, Hiram, Brownfield, Denmark, Sweden, Fryeburg, Lovell, Stow, and Stoneham  
 Region 8: York County; and Porter, Hiram, Brownfield, Denmark, Sweden, Fryeburg, Lovell, Stow, and Stoneham in Oxford County
- q. Does this facility have a gero-psychiatric unit?  
 Yes  No
- r. Do you serve the following?  
 Children  Adults  Both

- s. If you are Provider Type 67, 87, 88, or 89, do you employ at least one qualified speech language professional AND one qualified audiologist?

Note: If either of these professionals are contracted employees, you must answer "no" to this question.)

Note: A qualified speech language pathologist includes a Licensed Speech-Language Pathologist or a Certificate 293 – Speech and Language Clinician

Yes  No

If you answered "yes", what is the Effective Date of the simultaneous dual employment relationship?

Effective Date: \_\_\_\_\_

If you answered "no", enter the date that simultaneous dual employment ended, or, if not applicable, the current date.

Effective Date: \_\_\_\_\_

- t. Do you wish to participate in the 340B Drug Pricing Program?

Yes  No

If **no**, answer the questions below.

Is this a change to your current participation status?

Yes  No

If yes, what is the effective date of that change?

\_\_\_\_\_

If **yes**, answer the questions below.

Have you signed and received a fully-executed copy (signed by MaineCare) 340B Memorandum of Understanding (MOU)?

Yes  No

If **yes**, Please send a copy of this MOU to MaineCare Provider Enrollment, PO Box 1024, Augusta, ME 04332-1024

If **no**, please download the form at the link below or contact Provider Enrollment at 1-866-690-5585 (TTY:711). The form can also be accessed by going to the Provider page on the MIHMS Health PAS Online Portal. Click on "Forms" under Provider Documents, then click on Provider Enrollment.

<https://mainecare.maine.gov/Provider%20Forms/Forms/Publication.aspx?RootFolder=%2fProvider%20Forms%2fProvider%20Enrollment&FolderCTID=&View=%7b550DD634%2d668F%2d47E9%2dB0DD%2d93CDCC1CD721%7d>

What is the effective date of your participation?

\_\_\_\_\_

u. Please indicate which type of pharmacy services you provide (please note: you may only select ONE of the options below for each NPI/Pay to Provider):

- Traditional Retail Pharmacy
- Mail Order Pharmacy
- Specialty Pharmacy

*Mail Order Pharmacy Provider is a pharmacy provider that does not have a store front and dispenses prescription medications by U.S. mail or private carrier. This does not include a retail pharmacy or specialty pharmacy that occasionally mails a prescription to a member.*

*Specialty Pharmacy Provider is a pharmacy provider approved by the Department to dispense specialty drugs. Specialty Drugs are generally determined by price and distribution requirements. A Specialty Drug List is a list of covered drugs that the Department has determined may be obtained through Department-approved Specialty Pharmacy Providers. The Department posts and updates the Specialty Drug List on the mainecarepdl.org website.*

**4. License Information**

- |                                                                                                 |                                                                          |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Association of Operating Room Nurses (AORN)                            | <input type="checkbox"/> Massachusetts Board of Registration in Medicine |
| <input type="checkbox"/> Division of Licensing and Regulatory Services (Facility Standard)      | <input type="checkbox"/> New Hampshire State Board of Medicine           |
| <input type="checkbox"/> Licensing and Regulatory Services (Residential Care - Level III or IV) | <input type="checkbox"/> State of New Hampshire Online Licensing         |
| <input type="checkbox"/> Maine Board of Licensure in Medicine                                   | <input type="checkbox"/> U.S. Food and Drug Administration (Mammography) |
| <input type="checkbox"/> Maine Board of Osteopathic Licensure                                   | <input type="checkbox"/> Multi-systemic Therapy License                  |
| <input type="checkbox"/> Maine Board of Registration in Nursing                                 | <input type="checkbox"/> Other                                           |
| <input type="checkbox"/> Maine Office of Licensing and Registration (ALMS)                      | <input type="checkbox"/> Multiple                                        |

For all license choices except Other and Multiple, supply the number of your license in the Number field and provide dates for the Begin Date field and the End Date field.

If you chose Other or Multiple, you are required to include a photocopy of the license(s) when you submit your application.

For any license selection above except for Other or Multiple, supply the license number and effective dates below.

Number: \_\_\_\_\_

Begin Date\*: \_\_\_\_\_ End Date\*: \_\_\_\_\_

**Ambulance Services:**

Note: Ambulance services in Maine have no effective date; follow these instructions for filling out the license information for Ambulances.

- 1.) If your license is a renewal and you have been licensed without interruption, enter the date one day after the expiration of your previous license as the ambulance license effective date.

2.) If your license is your very first license, or if there has been a temporary discontinuation of your licensure, enter the day on which you first operated the ambulance to convey patients under the new license as the effective date of the license.

5. Certificate Information

- American Board for Certification (ABC) in Orthotics, Prosthetics & Pedorthics
- Board Certification in Molecular Genetics
- Council of Accreditation of Rehabilitation Facilities (CARF)
- Health Resource Services Administration (HRSA)
- Medicare Certification
- Psychiatry Board Certification
- Other
- Multiple

For all certificate choices except Other and Multiple, supply the number of your certificate in the Number field and provide dates for the Begin Date field and the End Date field.

You are required to include a photocopy of the certificate(s) when you submit your application.

For any certificate selection above except for Other or Multiple, supply the license number and effective dates below.

Number: \_\_\_\_\_

Begin Date\*: \_\_\_\_\_ End Date\*: \_\_\_\_\_

6. Education Information

Note: Education is required for the provider type Behavior Health Clinician with a specialty of Licensed Alcohol and Drug Counselor.

College, University, or Other Educational Institution \_\_\_\_\_

Last Date of Attendance \_\_\_\_\_

- Degree:
- Doctorate
  - Master's
  - Bachelor's
  - Degree not obtained

7. CLIA Information (if Yes to 3a above)

Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

- Level:
- 0 – No certification
  - 1 – Certificate of compliance
  - 2 – Certificate for provider-performed microscopy procedures
  - 3 – Certificate of accreditation
  - 4 – Certificate of registration (or registration certificate)
  - 5 – Certificate of waiver

**8. DEA Information** (if Yes to 3b above)

Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

- Level:  0 – No control  
 1 – Schedule 1  
 2 – Schedule 2  
 3 – Schedule 3  
 4 – Schedule 4  
 5 – Schedule 5

**9. JCAHO Information** (if Applicable)

Does the provider have a JCAHO number?  Yes  No

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**10. NABP Information** (if Applicable)

Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**11. Medicare Certificate Information** (if Applicable)

Number: \_\_\_\_\_ Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Part C. Facility Information**

Note: Complete this Part once for each service location.

1. Does this facility have a gero-psychiatric unit? \*  
 Yes  No

2. Do you serve the following? \*  
 Children  Adults  Both  Neither

3. What is the fiscal year end date? \*

\_\_\_\_\_

Use the format MM/DD.

4. Does this facility have a distinct part unit? \*  
 Yes  No

5. How many licensed beds are in this facility? \*

\_\_\_\_\_  
\_\_\_\_\_

6. How many Medicaid beds are in this facility? \*

\_\_\_\_\_

7. How many Medicare beds are in this facility? \*

\_\_\_\_\_

8. For pharmacies only, provide the following information:

Secure Fax # \_\_\_\_\_

NABP Chain Code \_\_\_\_\_

Chain Code Name \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

ZIP or Postal Code \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

State or Province \_\_\_\_\_

Country \_\_\_\_\_

Chain Code Start Date \_\_\_\_\_

Chain Code End Date \_\_\_\_\_

**Part D. Program Participation**

Note: Complete this Part once for each service location. Program Participation is applicable to In-State and Border state service locations. Border state service locations are those service locations in New Hampshire situated within 15 miles (24 km) of the Maine-New Hampshire border.

1. Does this service location currently participate in the Primary Care Case Management (PCCM) program? \*

- Yes.
- No. Do you want this site to participate in this program?  Yes  No

If this site currently participates in the PCCM program, you must also fill out Part E below.

2. Does this service location currently participate in the Maine Breast and Cervical Health program? \*

- Yes.
- No. Do you want this site to participate in this program?  Yes  No

3. Does this service location currently participate in the MaineRx program? \*

- Yes.
- No. Do you want this site to participate in this program?  Yes  No

4. Does this service location currently participate in the MaineCare Eye Care program? \*

- Yes.
- No. Do you want this site to participate in this program?  Yes  No

5. Does this service location provide non-Medicaid services at the request of Adult Protective Services? \*

- Yes  No

6. Does this service location provide non-Medicaid services to eligible children and families being served by the Child Welfare Program? \*

- Yes  No

7. Does this service location provide services to the children covered by the Children with Special Needs (CSHN) program? \*

- Yes  No

**Part E. PCCM Information**

Note: Complete this Part only if this service location currently participates in the PCCM program, as indicated in Part D of this form. Otherwise, continue with the next Section. All questions in this part are required.

1. What is the total number of patients in this location's site panel? \* \_\_\_\_\_

2. What are the minimum and maximum acceptable ages of patients that receive services at this location? \*

Minimum age: \_\_\_\_\_ years                      Maximum age: \_\_\_\_\_ years  
(For infants, use 0 years. For the maximum age, the greatest allowed value is 112 years.)

3. What limitations are there to the practice? Mark all that apply. \*

- Accepting existing patients only
- Accepting existing patients and their relatives only
- Accepting existing patients and newborns
- Accepting existing patients and new obstetrical patients
- Accepting existing patients and new obstetrical patients, relatives, and newborns
- Accepting existing patients and patients by referral
- Accepting existing patients only; no obstetrical patients
- Clinical limitations
- Female patients only
- Family practice, obstetrical and prenatal care
- Limited availability for new patients
- Local area patients only
- Native Americans only
- Obstetrical patients only
- Native American patients and their spouse and children
- Male patients only

4. Will this service location be an open PCP site (accepting new patients) or a closed PCP site (not accepting new patients)? \*

- This service location is an open PCP site.
- This service location is a closed PCP site.

5. What is the 24-hour phone number for this site? \*

\_\_\_\_\_

6. After regular office hours, how are phone calls handled? \*

Check all that apply.

- An answering service contacts the site or a covering Medicaid provider.
- An answering machine directs patients to call a covering Medicaid provider.
- Call forwarding transfers the calls to another location where someone can contact the site or a covering Medicaid provider.
- There is an alternate coverage arrangement. (Explain below.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What are the NPI numbers of the covering Medicaid providers for this location? \*

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8. The Department of Health and Human Services allows you to exclude certain patients from the PCP site when a lawsuit exists between you and the patient or when the patient has been formally discharged from your practice. Complete the fields below.

How many patients are excluded from this location? \* \_\_\_\_\_

What are the Medicaid IDs of the excluded patients? List one per line below.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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### SECTION 3. DOCUMENTATION

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In addition to this application, you must also complete, in their entirety, the documents that are included in your enrollment application packet. Be sure to label each document with the NPI and tax ID supplied in Section 1. To successfully complete the remainder of your enrollment application, follow the instructions included on the documents.

#### Part A. MaineCare Benefits Manual Attestations

For each of the following portions of the MaineCare Benefits Manual, check the box to indicate whether you have read and agree to abide by their terms and conditions. You can find these documents online at <http://www.maine.gov/sos/cec/rules/10/ch101.htm>.

- Chapter I of the MaineCare Benefits Manual
  - I attest that I have read and agree to abide by the terms and conditions of this document.
- Chapter II of the MaineCare Benefits Manual, Sections \_\_\_\_\_
  - I attest that I have read and agree to abide by the terms and conditions of these documents.
- Mental Health documentation
  - I attest that I have read and agree to abide by the terms and conditions of this document.

#### Part B. Documents

Complete each of the remaining enclosed documents, as indicated.

- Medicaid Provider Agreement
- Non-Medicaid Provider Agreement
- DME Storefront Rider
- Certified Public Expenditure Form

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### SECTION 4. SIGNATURE AND SUBMISSION

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Read the following statements and, if you are in agreement with them, sign and date where indicated below. Your application is incomplete without your signature.

- I certify that the information contained herein is true, correct, and complete.
- If I become aware that any information in this form is not true, correct, or complete, I agree to notify the Medicaid Provider Enrollment Unity of this fact immediately.
- I authorize the Medicaid Provider Enrollment Unit to verify the information contained herein.
- I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

\_\_\_\_\_  
Provider's signature

\_\_\_\_\_  
Today's date