
**MAINE INTEGRATED HEALTH MANAGEMENT SOLUTION
RENDERING PROVIDERS
PROVIDER MAINTENANCE FORM (MIHMS_MF_0008)**

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

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

- Add one or more new rendering providers
- Remove one or more existing rendering providers
- Update the information on file for one or more existing rendering providers

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 service location(s) refer to Maine Integrated Health Management Solution SERVICE LOCATIONS Provider Maintenance Form MIHMS_MF_0007.

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.

SECTION 1. IDENTIFYING INFORMATION

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.

SECTION 2. RENDERING PROVIDER(S)

If you are enrolling multiple rendering providers, you must provide a copy of this Section (pages 2-7) for each rendering provider.

Are you adding, removing, or updating information for a rendering provider?

- Adding a rendering provider
- Removing an existing rendering provider
- Updating information for an existing rendering provider

If you are adding a rendering provider 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. General Information

1. **What is the rendering provider's NPI? ***

2. **Complete the following fields regarding the rendering provider's name, contact information, and demographics.**

First and Last Name * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Gender * Male Female Unknown/prefer not to specify

Phone * _____ Fax _____

Part B. Provider Type and Specialties

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

- 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 *

2. Specialty *

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. 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

4. License Information

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

5. Certificate Information

- | | |
|--|---|
| <input type="checkbox"/> American Board for Certification (ABC) in Orthotics, Prosthetics & Pedorthics | <input type="checkbox"/> Health Resource Services Administration (HRSA) |
| <input type="checkbox"/> Board Certification in Molecular Genetics | <input type="checkbox"/> Medicare Certification |
| <input type="checkbox"/> Council of Accreditation of Rehabilitation Facilities (CARF) | <input type="checkbox"/> Psychiatry Board Certification |
| | <input type="checkbox"/> Other |
| | <input type="checkbox"/> 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.

If you chose Other or Multiple, 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. Medicare Certificate Information (if Applicable)

Number: _____ Begin Date: _____ End Date: _____

Part C. Program Participation

Note: Complete this Part once for each rendering provider.

1. Are you currently a Primary Care Case Management (PCCM) provider site? *

- 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. Are you currently enrolled in the Maine Breast and Cervical Health program? *

- Yes No

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

- Yes No

4. Do you currently participate in the MaineCare Eye Care program? *

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

5. Will you be providing non-Medicaid services at the request of Adult Protective Services? *

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

6. Will you be providing non-Medicaid services to eligible children and families being served by the Child Welfare Program? *

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

7. Do you provide services to the children covered by the Children with Special Needs (CSHN) program? *

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

Part D. PCCM Information

Note: Complete this Part only if this rendering provider currently participates in the PCCM program. Otherwise, continue with the next Part.

1. 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.)

2. 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

3. Is this rendering provider accepting new patients? *

- Yes No

Part E. Service Location Affiliation

List the service locations to which this rendering provider is affiliated. Specify the date on which the affiliation began and, if known, also include the date on which the affiliation will end. To identify a service location, use the identifying name and number that you indicated in the previous paper application.

Service Location Name and Number*	Begin Date* (MM/DD/YYYY)	End Date (MM/DD/YYYY)

SECTION 3. DOCUMENTATION

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

SECTION 4. SIGNATURE AND SUBMISSION

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