

MEDICAID TARGETED CASE MANAGEMENT

CHILDREN'S MEDICAL SERVICES, EARLY STEPS MEDICAID APPLICATION COMPLETION CHECKLIST

The following information is to be submitted to Florida Medicaid Provider Enrollment

<input type="checkbox"/>	1. Cover page should include the following information: <ul style="list-style-type: none">• Applicant Name and Phone Number• Contact Person and Phone Number
<input type="checkbox"/>	2. Completed Florida Medicaid Provider Enrollment Application The current version can be submitted electronically or printed from: https://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx Completion of the on-line application is highly recommended to expedite approval. Paper applications are mailed to: Florida Medicaid Provider Enrollment P.O. Box 7070 Tallahassee, Florida 32314-7070 Medicaid Provider Enrollment Telephone: 1-800-289-7799 Option 4
<input type="checkbox"/>	3. LES Service Coordinator Attestation Checklist
<input type="checkbox"/>	4. Copy of Social Security Card
<input type="checkbox"/>	5. Copy of Diploma (except registered nurses, see #5) Copy of college transcript if diploma does not state field of major or is for a degree other than psychology, social work, health education, interdisciplinary sociology, early childhood, child development or special education
<input type="checkbox"/>	6. Copy of Florida Nursing License (nurses only)
<input type="checkbox"/>	7. Completed <u>preprinted</u> fingerprint card Card may be obtained from your local Medicaid area office. The fingerprint card <i>must</i> be filled out completely. In the "Reason being fingerprinted" section, write "Medicaid Provider Enrollment." The card must be signed by the applicant and by the official taking the fingerprints.
<input type="checkbox"/>	8. Completed Non-Institutional Medicaid Provider Agreement This agreement may be printed from: https://portal.flmmis.com/FLPublic/Provider_Enrollment/tabId/50/Default.aspx

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INSTRUCTIONS FOR COMPLETING FLORIDA MEDICAID PROVIDER ENROLLMENT APPLICATION FOR CMS TARGETED CASE MANAGERS (CMS Early Steps, Medical Foster Care, and Primary Care Projects Contract Providers)

1. Name of Business or Individual: Enter applicant's last name, first name, middle initial and professional title (RN, SW, SC).
2. Doing Business As (D/B/A): Leave Blank
3. LES Service Coordinator Attestation Checklist that has been signed by the Early Steps State Office.
4. Tax Identification Number: Enter applicant's SSN and attach a copy of social security card.
5. Physical Street Address: Enter the local Early Steps, Medical Foster Care, or Primary Care Project business address; include the business name on the first line. Then complete the rest of the street address.
6. County Name: Enter the appropriate county for the address shown in number 4.
7. Business Location Telephone Number: Enter the applicant's business phone number.

Business Location Fax Number: Enter the applicant's business Fax number.

Contact Person: List the person who AHCA should contact if there are questions about the application package.

Contact Person's Telephone Number: Fill in the appropriate telephone number.
8. Business E-mail Address: Optional
8. Provider Type Code: Enter the two-digit code for the appropriate provider type. Select one of the following codes appropriate for case management billing providers:
 - Advanced Registered Nurse Practitioner - 30
 - Registered Nurse - 31
 - Social Worker and ES Service Coordinator - 32
9. Practice Type Code Enter 30.
10. Category of Service Code: Enter 75.
11. Specialty Code: Leave Blank
12. License Information: For nursing professionals, enter the Florida License number and attach a copy of the license.
 - Facility license number: Leave Blank
 - CLIA License number: Leave Blank

MEDICAID TARGETED CASE MANAGEMENT

13. NPI Number: Enter the individual's nine-digit NPI number.
14. Medicare Number: Leave Blank
15. Provider Handbooks: Check box if you wish to receive provider handbooks by mail.
16. Collaboration Agreement for Individual PA and ARNP: Requires a CMS physician or dentist to sign and provide his/her Florida license number.
17. Ownership Certification for Physician Groups: Leave Blank
18. Home Medical Equipment License Exemption: Leave Blank
19. Pharmacy Information: Leave Blank
20. Group Membership Information for Individual Providers:
 - a. Enter *Group Provider Number*. Leave Effective Date blank
 - b. Check *No*
21. Billing Agent Agreement: Leave Blank
22. Electronic Claims Submission: Leave Blank
23. Electronic Remittance Voucher: Leave Blank
24. Mailing Address for Payment: Leave Blank
25. Payment Method: Go to *Option 2* and enter *Group Number*
26. Change of Ownership: Check *No*
27. Ownership Code: From appendix E, enter either:
 - 1 - County Owned;
 - 2 - State Owned;
 - 5 - Privately Owned, For-profit
 - 6 - Privately Owned, Not-for-profit)
28. Records Custodian(s): Complete information for both *a.* and *b.*
29. Owner(s) and Operator(s): Enter information for applicant.
 - Relationship is *Owner* or *Director*
 - % Owner is *100%*
30. Applicant History: Referring to the individual applicant, questions *a.* through *f.* must be answered *Yes* or *No*.

CERTIFICATION

Complete the signature block. The application must contain an original signature and date. The applicant's signature on the application attests to the fact that all information included in the Enrollment Application is correct and complete.