UNM HEALTH SCIENCES CENTER

"UNMMG, INC" Billing Packet Checklist

To be Compliant with your service agreement, Federal/State laws, and UNMHSC policies, submission of specific documentation copies are required to be submitted in conjunction with this packet.

Required Document Copies	MD	DO	CNP	PA	CNM	CRNA	AA	PhD	RD	OD	DDS	SLP
Curriculum Vitae/Resume (professional school to present) * Must indicate month/year can contain explanation for gaps greater than 30 days.	X	X	X	X	X	X	X	X	X	X	X	X
Current New Mexico State Board License.	X	X	X	X	X	X	X	X	X	X	X	X
Current Drug Enforcement Administration (DEA) Certificate.	X*	X*	X*	X*	X*	X*				X*	X*	
Current New Mexico State Board of Pharmacy Certificate (CSR).	X*	X*	X*	X*	X*	X*				X*	X*	
Diplomas: * Medical/Professional School, * Residency, * Internship, * Fellowship.	X	X	X	X	X	X	X	X	X	X	X	X
Educational Commission for Foreign Medical Graduate (ECFMG) Certificate, if applicable.	X	X										
Current Board Certification - Specialty and Subspecialty.	ABMS or AA	AOA	ANCC or NCC	NCCPA	ACNM	AANA or CRNA	NCCAA		CDR	AAO		
Current Driver's License.	X	X	X	X	X	X	X	X	X	X	X	X

* Note; If you do not have a Federal DEA and/or NM Board of Pharmacy Certificate(s), you must include a signed statement stating such and/or that you are not required to have.

Instructions for completion are inserted at the beginning of each individual application/form. Please read the instructions for each application/form carefully. Complete only items as indicated. All information should reflect and applies to your new position at UNMHSC. Also be advised that Government Policy does not allow "whiteout" for correcting errors. Please make changes by placing a line through the erroneous entry and writing the correct information beside the "lined out" entry.

USE BLUE INK ONLY WHEN COMPLETING THE FOLLOWING FORMS

Requested document copies and the entire "UNMMG, INC" Billing Packet (completed and signed), can be sent to:

Your Department Credentialing Liaison.

PLEASE NOTE: Billing processes will not and cannot begin until all required information/documentation have been received and sent to the Coordinator Provider Enrollment - No Exceptions!

UNMMG BILLING NUMBER REQUEST FORM

This form is for requesting a billing number to bill through UNMMG. Please **complete** questions 1 - 20, sign and date. We will use this form to complete repetitious information on the other forms for you.

UNM MEDICAL GROUP, INC.
BILLING NUMBER REQUEST FORM

1. Physician/Provider Name: _____ (Last) , _____ (First) , _____ (Middle)

2. Title (X): MD _____ PA _____ NP _____ OTHER _____ (List Type)

3. Are you (X): UNM Employee _____ UH Employee _____ UNMMG Employee _____

4. Are you (X): FACULTY _____ RESIDENT/FELLOW _____ STAFF _____ OTHER _____

4a. Faculty Status (X): Professor _____ Assistant Professor _____ Associate Professor _____
Adjunct Professor _____ Volunteer _____ Instructor _____ Lecturer _____
Staff Provider _____ Other _____ (List)

5. Start Date: _____

6 Date of Birth: _____
6a. Birth Place: _____
6b. Sex: Male _____ Female _____

7. Social Security Number: _____

8 DEA Number: _____
8a. DEA Expiration Date: _____

9. Provider License #: _____ **Original** Date Issued: _____ (MMDDYY) Expiration Date: _____ (MMDDYY)

10. Certification Board: _____ Certification Number: _____ Certification Date: _____ (MMDDYY)

11. Medical/Professional School: _____ **11a.** Date Graduated: _____ (MMDDYY)

12. FTE Status (X): 1.0 (FT) _____ 0.5 _____ Other _____
Change in FTE Status _____

13. Is this a (X): New Hire _____ Change in Department/Specialty _____
Addition to Department/Specialty _____

14. If less than full time, list concurrent practice address:
_____ (Address) _____ (City) _____ (State) _____ (Zip Code)

15. Prior practice information and dates:
_____
_____

16. Albuquerque Home Address and Telephone Number:
_____ (Address) _____ (City) _____ (State) _____ (Zip Code)
_____ (Home Number) _____ (Cell Number)

17. Driver's License # & State: _____, and Expiration Date: _____ (MMDDYYYY)

18. Department: _____ _____ (Specialty)
_____ (Subspecialty)

19. Provider NPI number: _____
NPI User ID : _____ NPI User Password: _____

20. If you have a New Mexico Medicare/Medicaid/Welfare number, Please list: _____

_____ (Signature) _____ (Date)

Medicaid - Provider Participation Agreement/Application

Use BLUE INK ONLY

1. Answer and initial questions A, B, C, on Page 11 and sign where indicated in the middle of the page.

HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
MEDICAL ASSISTANCE DIVISION
PROVIDER PARTICIPATION AGREEMENT
INDIVIDUAL APPLICANT WITHIN GROUP

Name of Individual	SSN	NPI

A) Have you ever had a license revoked, suspended or denied in any state? ___YES ___NO Initial_____

B) Have you ever been convicted of any criminal offense? ___YES ___NO Initial_____

C) Have you or any ever been excluded or suspended from participation in Title XVII (Medicare), Title XIX (Medicaid) or any other health care program? ___YES ___NO Initial_____

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result.

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person: _____ ***Telephone Number:*** _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use blue ink only.

INDIVIDUAL PROVIDER:

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____

Signature of Individual Practitioner: _____ Date _____

FOR STATE PURPOSES ONLY:

HUMAN SERVICES DEPARTMENT APPROVAL

☐ APPROVED ☐ NOT APPROVED

Reasons Not Approved:

Dates of Agreement: From: _____

Authorized Signature	Date

UNM MedicalGroup, Inc.
University of New Mexico Physicians

Office of Clinical Contract Services
801 University Blvd. SE, Suite 200
Albuquerque, New Mexico 87106

PHONE: 505-272-8950
FAX: 505-272-6276
WEB SITE: https://sp-unmmg.health.unm.edu/OMCS/LeadershipTeam/OCCS/SitePages/Provider%20Enrollment.aspx

Dear Provider,

CMS Medicare (Centers for Medicare & Medicaid Services), requires that we use your NPI User ID and Password in applying for your Medicare number on the PECOS on-line application system.

UNMMG Provider Enrollment needs your user ID & Password that is linked to your National Provider Identifier (NPI) along with your consent to manage all provider NPI information on your behalf.

If you do not have this information because someone (your previous group practice, employer, and/or medical school) applied on your behalf, the governmental agency that issues the NPI number (NPPES) requires you (the provider) to personally contact the enumerator (NPPES) to obtain this information.

- Please Call the NPI Enumerator at 1-800-465-3203
- Choose Option "NPI Specialist"
- You will be asked a few identifying questions confirming your identity then they will give you your USER ID and re-set your PASSWORD.

Provider First & Last Name	**NPI**
USER ID (this is case-sensitive)	**Password (this is case-sensitive)**

CMS also requires the provider choose and answer 5 security questions, Please provide the answers for the following questions:

What is the name of your first pet? _____
What was the color of your first car? _____
What size shoe do you wear? _____
What is your favorite movie? _____
What is the model of your first car? _____

I authorize UNMMG Provider Enrollment to update any and all information as needed on my NPI profile.

Signature: _____ Date _____

Should you require additional information or have questions please feel free to contact:

UNMMG Provider Enrollment Department
Office of Clinical Contract Services
801 University Blvd. SE, Suite 200
Albuquerque, New Mexico 87106-4375
Phone: (505) 272-8950 / Fax: (505) 272-6276

SECTION 5: CONTACT PERSON INFORMATION (Optional)

If questions arise during the processing of this reassignment, the designated MAC will contact the individual indicated below. If a contact person is not furnished, the MAC will contact the individual practitioner is Section 3.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
Renee	A	Baughman	

Contact Person Address Line 1 *(Street Name And Number)*
933 Bradbury Dr SE

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*
Ste 2222

City/Town	State	ZIP Code +4
Albuquerque	NM	87106

Telephone Number	Fax Number *(if applicable)*	Email Address *(if applicable)*
(505) 272-1476		rbaughman@unmmg.org

Relationship or Affiliation to Individual or Organization/Group *(Spouse, Secretary, Attorney, Billing Agent, etc.)*
Delegated Official

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this reassignment. The designated MAC will not discuss any other Medicare issues about the organization/group or individual practitioner beyond this reassignment application with the above Contact Person.

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 CFR § 424.73 and 42 CFR § 424.80. All individual practitioners who allow another individual or organization/group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf.

The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group shown in Section 2.

The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 CFR § 424.80.

These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Renee	A	Baughman	

Delegated or Authorized Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of 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 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.
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 into 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 to provide health care 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 billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS *(Continued)*

FINAL ADVERSE LEGAL ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed on page 12 of this application imposed against you?

☐ YES–Continue Below	☐ NO–Skip to Section 4

2. If yes, 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.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing the Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry to or revoked from the Medicare program if any requirements are not met.

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact in accordance with the time frames established in 42 CFR § 424.516.
2. I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of a change in ownership, practice location and/or Final Adverse Action within 30 days of the reportable event. In addition, I agree to notify the Medicare contractor of any other changes to the information to this form within 90 days of the effective date of change. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither I, nor any managing employee listed on this application, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to me (or to the organization listed in Section 4A of this application) by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number issued to me can only be used by me or by a provider or supplier to whom I have reassigned my benefits under current Medicare regulations, when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)

☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.

☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).

☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.

☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.

☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)

☐ Copy of current CLIA and FDA certification for each practice location reported.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

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