MEDICAL GROUP, INC.

UNM Medical Group, Inc Billing Packet

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

Required Documents	MD	DO	CNP	PA	CNM	CRNA	AA	PhD	LD	OD	DDS/ DMD	All Other providers	✓
Curriculum Vitae/Resume (professional school to present) *Must indicate month/year and contain explanation for gaps greater than 30 days.	X	X	X	X	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	
Billing Area Checklist for appropriate clinic/department.	X	X	X	X	X	X	X	X	X	X	X	X	

Instructions for completion are inserted at the beginning of each individual 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 ALL FORMS

Requested document copies and the entire "UNMMG, INC" Billing Packet (completed and signed), can be sent to: Your Department Credentialing Enrollment Liaison.

PLEASE NOTE: Billing processes will not and cannot begin until all required information/ documentation has been Received and reviewed by 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. 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**: _____
_____

_____ (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

MEDICAL GROUP, INC.

Office of Clinical Contract Services
933 Bradbury Drive SE, Suite 2222
Albuquerque, NM 87106-4301

PHONE 505-272-1476
FAX 505-272-3789
WEB SITE http://hsc.unm.edu/unmmg

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 EUS (External User Services) 1-866-484-8049

Provider Name: First and Last	**NPI**
USER ID(this is case sensitive)	**Password (this is case sensitive)**

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

Signature_____ Date_____

Medicare- Provider Participation Agreement Application

USE BLUE INK ONLY

1. Complete Section 2G or 2H on page 7
(Depending on provider type)

2. Complete Section 15B on page 23 and Section 6A on page 3

SECTION 13: CONTACT PERSON INFORMATION *(Optional)*

If questions arise during the processing of this application, your designated MAC will contact the individual reported below.

☐ Contact the individual listed in section 2A of this application as the designated contact person.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: _____

First Name	Middle Initial	Last Name	Jr., Sr., MD., etc.
Renee		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)*	E-mail Address *(if applicable)*
505-272-1476		rbaughman@unmmg.org

NOTE: The Contact Person listed in this section will only be authorized to discuss issues concerning this or any other enrollment application. Your designated MAC will not discuss any other Medicare issues about you with the above Contact Person.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. section 1001 authorizes criminal penalties against an individual who, 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 makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. section 3571). section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who, with actual knowledge, deliberate ignorance or reckless disregard of truth or falsity (a) presents or causes to be presented to the United States Government or its contractor or agent a false or fraudulent claim for payment or approval; (b) uses or causes to be used a false record or statement material either to a false or fraudulent claim or to an obligation to pay the Government; (c) conceals or improperly avoids or decreases an obligation to pay or transmit money or property to the Government; or (d) conspires to violate any provision of the False Claims Act. The False Claims Act imposes a civil penalty of between $5,000 and $10,000 per violation, as adjusted for inflation by the Federal Civil Penalties Inflation Adjustment Act, 28 U.S.C. 2461, plus three times the amount of damages sustained by the Government.
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any state agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or

   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and state health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The United States Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

F. RESIDENT INFORMATION *(Continued)*

3. Do you also render services at other facilities or practice locations? ☐ YES ☐ NO
   If YES, you must report these practice locations in section 4B and/or section 4F.

4. Are the services that you render in any of the practice locations you will be reporting in section 4B and/or section 4F part of your requirements for graduation from a residency program? ☐ YES ☐ NO
   If YES, has the teaching hospital/facility reported in section 2F1 above agreed to incur all or substantially all of the costs of your training in the non-hospital/facility location? ☐ YES ☐ NO

G. PHYSICIAN SPECIALTY

Designate your primary specialty and all secondary specialty(s) below using:

P=Primary S=Secondary

You can only select one primary specialty. If you have multiple primary specialties, you must complete and submit a separate CMS-855I application for each primary specialty. You may select multiple secondary specialties. A physician must meet all federal and state requirements for the type of specialty(s) checked.

- ☐ Addiction Medicine
- ☐ Advanced Heart Failure and Transplant Cardiology
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac Electrophysiology
- ☐ Cardiac Surgery
- ☐ Cardiovascular Disease (Cardiology)
- ☐ Chiropractic
- ☐ Colorectal Surgery (Proctology)
- ☐ Critical Care (Intensivists)
- ☐ Dentist
- ☐ Dermatology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine
- ☐ Endocrinology
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ Geriatric Psychiatry
- ☐ Gynecological Oncology
- ☐ Hand Surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hematopoietic Cell Transplantation and Cellular Therapy
- ☐ Hospice/Palliative Care
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Interventional Cardiology
- ☐ Interventional Pain Management
- ☐ Interventional Radiology
- ☐ Maxillofacial Surgery
- ☐ Medical Genetics and Genomics
- ☐ Medical Oncology
- ☐ Medical Toxicology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear Medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Optometry
- ☐ Oral Surgery
- ☐ Orthopedic Surgery
- ☐ Osteopathic Manipulative Medicine
- ☐ Otolaryngology
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatric Medicine
- ☐ Peripheral Vascular Disease
- ☐ Physical Medicine and Rehabilitation
- ☐ Plastic and Reconstructive Surgery
- ☐ Podiatry
- ☐ Preventive Medicine
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Sports Medicine
- ☐ Surgical Oncology
- ☐ Thoracic Surgery
- ☐ Undersea and Hyperbaric Medicine
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Undefined Physician Specialty *(Specify)*:_____

SECTION 2: PERSONAL IDENTIFYING INFORMATION *(Continued)*

H. ELIGIBLE PROFESSIONAL OR OTHER NON-PHYSICIAN SPECIALTY TYPE

If you are an eligible professional, check the appropriate box below to indicate your specialty.

All individuals must meet specific licensing, educational, and work experience requirements. If you need information concerning the specific requirements for your specialty, contact your designated MAC.

Check only one of the following: If you have multiple non-physician specialty types, you must complete and submit a separate CMS-855I application for each non-physician specialty type.

- ☐ Anesthesiology Assistant
- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Certified Clinical Nurse Specialist (CNS) (See section 2L)
- ☐ Clinical Social Worker
- ☐ Mass Immunization Roster Biller (See section 2L)
- ☐ Nurse Practitioner (See section 2L)
- ☐ Occupational Therapist In Private Practice (See section 2K)
- ☐ Physical Therapist In Private Practice (See section 2K)
- ☐ Physician Assistant (See section 2I)
- ☐ Psychologist, Clinical (See section 2J)
- ☐ Psychologist Billing Independently (See section 2J2)
- ☐ Qualified Audiologist
- ☐ Qualified Speech Language Pathologist
- ☐ Registered Dietitian or Nutrition Professional
- ☐ Undefined Non-Physician Practitioner Specialty *(Specify)*: _____

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT	EMPLOYER'S PTAN *(if issued)*	EMPLOYER'S NPI	EMPLOYER'S EIN

2. Physician Assistants: Terminating Employment Arrangement(s)
Complete this section if you are a PA discontinuing a current employment arrangement(s).

EMPLOYER'S NAME	EFFECTIVE DATE OF EMPLOYMENT TERMINATION	EMPLOYER'S PTAN	EMPLOYER'S NPI	EMPLOYER'S EIN

3. Employer Terminating Employment Arrangement with One or More Physician Assistants
Complete this section if you are a health care provider corporation formed by an individual, a single member LLC with an EIN, or a sole proprietor and you are discontinuing the employment arrangement of a PA(s). Health care provider corporations formed by an individual, single member LLC with an EIN, and sole proprietors must also complete section 4A1 with your organizational information.

PHYSICIAN ASSISTANT'S NAME	EFFECTIVE DATE OF TERMINATION	PHYSICIAN ASSISTANT'S PTAN	PHYSICIAN ASSISTANT'S NPI

SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

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 this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

A. 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.

Under the penalty of perjury, 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 my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. 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 the business structure of my private practice 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, may be punishable 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 Medicare Administrative 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, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a 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 my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled 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 and the signature below is my signature.

B. SIGNATURE AND DATE

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

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

In order to process this application it MUST be signed and dated.

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		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.)*

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.

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.