



Dear Applicant:

Thank you for choosing to become a Montana Medicaid Provider. For your convenience, we are providing a checklist to ensure that your provider enrollment form is completed correctly. All sections of the provider enrollment form must be completed in order for us to process your application. **Incomplete applications will be returned.** This application has been designed to comply with federal program requirements. We cannot accept alterations to the provider agreement text on pages 4 and 5.

You will be notified in writing of the status of your enrollment request within fifteen (15) working days of receipt at our office. Please do not bill Montana Medicaid for any services until you have received, in writing, notice of your provider number and its effective date. Claims submitted prior to completion of provider enrollment will be denied.

If you have any questions regarding information required on the enrollment application, please contact ACS Provider Relations at 1-800-624-3958 (in-state only) or 406-442-1837 (out-of-state and Helena).

All Providers

- ___ 1. Complete and sign the enclosed application.

If the application is for an individual, the individual who will be providing the service must sign it.

If the application is for a facility, an individual authorized to enter the facility into a legal contract must sign it.

- ___ 2. Complete Question 21 unless you are a Public Health Clinic or a facility with a non-profit tax status (indicate non-profit for Question 7 and on your W-9). An incomplete response to Question 21 will result in the enrollment form being returned.

If the enrolling facility is a non-profit organization or if no individual in the facility has controlling interest of five percent (5%) or more, please enter the information of the person who is the managing officer of the facility as a contact person.

- ___ 3. Enclose a **photocopy of your current license** showing an effective and expiration date. If you are enrolling to bill for services already provided, also enclose a photocopy of your license covering that date of service. You may also be required to enclose a photocopy of your Medicare Certification Notice. Retroactive enrollment is not guaranteed.
- ___ 4. Include a letter of termination if you are changing ownership or your tax ID. These changes require you to terminate your old provider number and apply for a new provider number. The termination letter needs to contain the following information: the provider number to be terminated, the termination date, and the effective date of the new provider number. The termination date of your previous number must be after any dates of service for which claims were billed utilizing that provider number.
- ___ 5. On page 2, No. 10, please indicate the date that you want your provider number to be effective.
- ___ 6. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Direct Deposit Sign-Up Form (Standard Form 1199A). Failure to return this form will result in the entire provider enrollment package being returned to the provider. **Providers enrolling for new provider numbers cannot choose options 3 or 4 on this form.**
- ___ 7. All providers enrolling as of January 1, 2004 for new provider numbers must complete and return a Electronic Remittance Advice and Payment Cycle Enrollment Form. Failure to return this form will result in the entire provider enrollment package being returned to the provider.

Laboratory Services

- ___ If you bill laboratory services, you must enclose a copy of your CLIA certification.

Pharmacy

- ___ If you are enrolling due to a change in ownership or tax ID change and you assume the former provider's NABP number, you must indicate an effective date after the termination date for the previous provider.

Montana Medicaid Provider Enrollment Application

Please type or block print the requested information as completely as possible. If any field is not applicable, please enter N/A. If you need extra space to answer any question, please attach an additional page. An incomplete form may delay the approval of this application. Please direct questions to the ACS Provider Relations Unit at (800) 624-3958 (Montana) or (406) 442-1837 (Helena and out-of-state).

For Fiscal Agent Use Only	
ACS Assigned Provider Number	Approval Date
_____	_____

IMPORTANT: PLEASE READ INSTRUCTIONS ABOVE QUESTIONS COMPLETELY BEFORE PROCEEDING.

1. Enter your **business or provider name** and address below. **(Physical address is required.)**

 Name

 Address

 City _____ State _____ Zip _____
2. Enter your **practice telephone** and fax number.
 (____) _____ - _____
 (____) _____ - _____ (Fax)
3. Enter your two-digit **County Location Code**. Refer to *Table 1a or 1b* included in this enrollment application.
 _____ / _____
4. Enter your two-digit **Provider Type Code**. Refer to *Table 2* included in this enrollment application. _____ / _____
5. Enter your most current **Professional License Number**, state where issued, effective date and expiration date in MMDDYY format. The provider type indicated in Question 4 will determine which certification/license requirements must accompany your enrollment. Please refer to *Table 4*. **(ATTACH A COPY OF YOUR LICENSE.)**
 _____ / _____ / _____
 License Number State Effective Date Expiration Date
6. Enter the two-digit **specialty code, board certified information, certification date in MMDDYY format, and certification number**. Refer to *Table 3* included in this enrollment application.
 Specialty Code: _____ Board Certified (Yes/No): _____
 Certification Date: _____ Certification Number: _____
7. Enter your one-digit **Type of Ownership Code**. Refer to the following *table* for codes. _____

1 – Individual	3 – Corporation	5 – HMO	7 – Clinic
2 – Partnership	4 – Hospital Based	6 – Group	
8. Enter the **Federal Identification Number of the business OR the Social Security Number** of the individual for which this application is being filed. Use the number you wish all income to be reported for Federal 1099 purposes and match the information indicated on your W-9.
 FEIN _____ or SSN _____
9. If you have previously billed Montana Medicaid, indicate the provider number you used: _____
10. Have you already provided services to a Montana Medicaid recipient? No Yes
 If yes, enter the earliest date of service. _____ **Attach a copy of your license to cover this time period.**

11. Enter your **Drug Enforcement Agency (DEA) number**. If you do not have a DEA number, enter N/A in this space. If you are a physician, you **must** enter this information. _____

12. Enter your **fiscal year end month**: _____

13. If you bill laboratory services, you must enter your ten-digit **Clinical Laboratory Improvement Amendments (CLIA) number**, CLIA type, and effective and termination dates in MMDDYY format. CLIA type values are listed below.

1 Registration
4 Wavier

2 Regular Certificate
5 Microscopy

3 Accreditation
6 Partial Accreditation

_____ / _____ / _____
CLIA Number CLIA Type Effective Date Termination Date

14. **Pay to:** If you wish to direct your Remittance Advice to an address other than your practice address, enter that information here.

Pay to Address: _____

Correspondence: If you wish to have all Medicaid related correspondence sent to an address other than your practice address, enter that information here. **Please note that ACS can only store two provider addresses. Example: If your correspondence address is different than your payment or practice address, we cannot cross-reference the third address.**

Correspondence Address: _____

15. **For Hospitals Only:** Before payment can be made to your hospital for services provided to Montana Medicaid recipients, the name and address of your Medicare intermediary **must** be provided. Hospitals must attach a complete copy of worksheets A, A8, C Part 1 and G2 of their most recent Medicare cost reports. Enrollment forms received without the cost report worksheets attached will be returned to the provider for completion.

Medicare Intermediary Address: _____

16. **For Pharmacies Only:** Enter your **National Association of Boards of Pharmacy (NABP) number**. _____
If you are a pharmacy that has purchased another pharmacy, do you wish to keep the same dispensing fee? No Yes

17. **For HMO and PASSPORT providers only:** Enter your **24-hour access telephone number**: (_____) _____ - _____

18. If you are enrolled in the Medicare program, enter the **Unique Physician Identification Number (UPIN)** assigned to you:

19. If you enrolled as a Medicare provider, enter your **Medicare number** if you wish to have your claims automatically transferred from Medicare to Medicaid: _____

20. If you have been assigned a **National Provider Identifier (NPI)** number, enter your NPI number: _____

21. OWNERSHIP INFORMATION

(Copy this page and complete for each person who has an ownership or control interest of 5% or more, OR is an agent or managing employee in this provider entity.)

A. Name (First, Middle, Last, Jr., Sr., MD, DO, etc.)		Date of Birth	
County/State/Country of Birth		Social Security Number	Montana Medicaid No.
Are you the spouse, parent, child, or sibling of other persons who have an ownership or control interest of 5% or more, OR an agent or managing employee in this provider entity? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, give name of person and relationship.)			
Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any Federal agency or program: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:			
B. Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? <input type="checkbox"/> No (Go to Section C.) <input type="checkbox"/> Yes (Fill in the following for each organization. Attach a copy of the organization's form IRS-P575 or, if not available, the W-9.)			
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:	
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:	
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:	
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:	
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:	
C. Parent/Joint Venture Information Is your organization a subsidiary company or joint venture? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, fill in the following information about your parent company/joint business.			
Legal Business Name:	Employer ID No:	Medicaid ID No:	
Business Street Address Line 1			
Business Street Address Line 2			
City	County	State	Zip
Phone Number		Fax Number	

DEFINITIONS

Ownership interest means equity in the capital, the stock or the profits of the provider.

Person with an ownership or control interest means a person, partnership, corporation or other entity that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the provider or in an entity that has an indirect ownership interest in the provider.

22. For Home and Community Based Providers Only

This section is used by the Home and Community Based Services Program (provider type 28) to designate negotiated services and rates for Home and Community Based Service Providers. Medicaid payment for Home and Community Based Services will be made only if the Program has identified the approved procedure codes and rates for the provider (completed after application is sent in).

Procedure Code	Rate	Effective Date
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Authorizing Program Officer Signature

Date

23. INDIVIDUAL ENROLLMENTS ONLY: The U.S. Department of Health and Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.

Gender: Male Female

Race: Asian or Asian American or Pacific Islander Hispanic White (not Hispanic) Black (not Hispanic) or African-American North American Indian or Alaska Native

Printed Name of Person Filling out Form: _____ Date: _____

Signature of Person Filling Out Form: _____ Telephone #: _____

Provider Agreement and Signature

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills Medicaid will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply, as of December 1, 1991 and throughout the remaining term of this enrollment, with the applicable advance directive requirements of Section 1902(w) of the Social Security Act.

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (4-88) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or and any active connected with the provision of Medicaid services.

All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider further agrees to, in accordance with relevant laws, regulations and policies, including the 1996 Department Policy on Confidentiality of Client Information, protect the confidentiality of any material and information concerning an applicant for or recipient of Medicaid services.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively the Department for the rate period.

The Provider agrees to notify ACS at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought. 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:
Or for facilities and non-practitioner organizations:	
Printed Name of Authorized Representative	Title/Position:
Address:	Telephone Number:
Signature of Authorized Representative:	Date:

Please mail this completed enrollment form to: ACS
 Provider Enrollment Unit
 P.O. Box 4936
 Helena, MT 59604

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ <input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Social security number								
or								
Employer identification number								

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is **disregarded as an entity** separate from its owner (see **Limited liability company (LLC)** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**,

Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see **Exempt from backup withholding** above.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN or:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give name and EIN or:
6. Sole proprietorship	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.



Table 1a
Montana County Codes

01	Beaverhead	16	Gallatin	31	Mineral	46	Sheridan
02	Big Horn	17	Garfield	32	Missoula	47	Silver Bow
03	Blaine	18	Glacier	33	Musselshell	48	Stillwater
04	Broadwater	19	Golden Valley	34	Park	49	Sweet Grass
05	Carbon	20	Granite	35	Petroleum	50	Teton
06	Carter	21	Hill	36	Phillips	51	Toole
07	Cascade	22	Jefferson	37	Pondera	52	Treasure
08	Choteau	23	Judith Basin	38	Powder River	53	Valley
09	Custer	24	Lake	39	Powell	54	Wheatland
10	Daniels	25	Lewis & Clark	40	Prairie	55	Wibaux
11	Dawson	26	Liberty	41	Ravalli	56	Yellowstone
12	Deer Lodge	27	Lincoln	42	Richland	70	Warm Springs
13	Fallon	28	Madison	43	Roosevelt	71	Galen
14	Fergus	29	McCone	44	Rosebud	72	Boulder
15	Flathead	30	Meagher	45	Sanders	74	Eastmont

Table 1b
Out-of-State County Codes

AL	Alabama	IL	Illinois	NE	Nebraska	RI	Rhode Island
AK	Alaska	IN	Indiana	NV	Nevada	SC	South Carolina
AZ	Arizona	IA	Iowa	NH	New Hampshire	SD	South Dakota
AR	Arkansas	KS	Kansas	NJ	New Jersey	TN	Tennessee
CA	California	KY	Kentucky	NM	New Mexico	TX	Texas
CO	Colorado	LA	Louisiana	NY	New York	UT	Utah
CT	Connecticut	ME	Maine	NC	North Carolina	VT	Vermont
DE	Delaware	MD	Maryland	ND	North Dakota	VA	Virginia
DC	District of Columbia	MA	Massachusetts	OH	Ohio	WA	Washington
FL	Florida	MI	Michigan	OK	Oklahoma	WV	West Virginia
GA	Georgia	MN	Minnesota	OR	Oregon	WI	Wisconsin
HI	Hawaii	MS	Mississippi	PA	Pennsylvania	WY	Wyoming
ID	Idaho	MO	Missouri				

**TABLE 2
PROVIDER TYPES**

01	Inpatient Hospital	17	Psychologist	35	Nutritionist	55	Rural Health Clinic
02	Outpatient Hospital	18	Dentist	38	Residential Treatment Center	56	FQHC
03	Swing Bed Hospital	19	Pharmacy	39	ICF – Mentally Retarded	58	Licensed Professional Counselor
04	EPSDT	20	Durable Medical Equipment	40	Lab and X-Ray	59	Mental Health Center
05	Podiatrist	21	Optometrist	42	Licensed Social Worker	60	Targeted Case Management (Mental Health Only)
06	Physical Therapist	22	Eyeglasses	43	Denturist	61	Therapeutic Group Home
07	Speech Therapist	23	Transportation – Common	44	Mid-level Practitioner	63	Public Health Clinic
08	Audiologist	24	Non-Emergency Transport	45	Schools	64	Therapeutic Foster Care
09	Hearing Aids	25	Ambulance	46	Home Infusion Therapy	65	Psychiatrist (MD or DO)
10	Occupational Therapist	26	Nursing Home	47	Eyeglasses Contractor	66	CHIP Dental
12	Personal Care	27	Physician	50	QMB Chiropractor	72	Independent Diagnostic Testing Facility
13	Home Dialysis	28	Home and Community Based	52	Freestanding Dialysis Clinic	99	EDI Billing Agent
14	Private Nursing	29	Targeted Case Management (Non-Mental Health)	53	Home Health	NP	Mail Only Provider
15	Ambulatory Surgical Center	32	Rehabilitation	54	Hospice		

**TABLE 3
PROVIDER SPECIALTIES**

01	General Practice	23	Peripheral Vascular Disease or Surgery	52	Rheumatology	74	Targeted Case Mgmt Pregnant Women
02	General Surgery	24	Plastic Surgery	53	General Dentist	75	Head Start
03	Allergy	25	Physical/Rehab Medicine	54	Neonatology	76	Community Mental Health
04	Otology/Laryngology	26	Psychiatry	55	Oncology	77	Nurse Midwife
05	Anesthesiology	27	Psychiatry Neurology	56	Respiratory Therapy	78	Home Infusion Therapy
06	Cardiovascular Disease	28	Proctology	57	School Based Services	79	Retail Pharmacy
07	Dermatology	29	Pulmonary Diseases	58	Other EPSDT	80	Orthotics/Prosthetics
08	Family Practice	30	Radiology	59	Chemical Dependency	81	Orthodontist
09	Gynecology	31	Roentgenology, Radiology	60	Therapeutic Group Care	82	Interpreter Services
10	Gastroenterology	32	Radiation Therapy	61	Therapeutic Foster Care	83	Managed Care Community
11	Internal Medicine	33	Thoracic Surgery	62	Other Rehab	84	Registered Nurse Anesthetists
12	Manipulative Therapy	34	Urology	63	Inpatient Psychiatric	85	Hospital Pharmacy
13	Neurology	35	Chiropractor	64	Residential Treatment	86	Nursing Facility Pharmacy
14	Neurological Surgery	36	Nuclear Medicine	65	Outpatient Hospital Lab	87	Pedodontist
15	Obstetrics	37	Pediatrics	66	Eyeglass Material Supplier	88	Endocrinology
16	OB-Gynecology	38	Geriatrics	67	Wheelchair Supplier	89	TCM Mental Health
17	Ophthalm-Ot-Laryng-Rhinology	39	Nephrology	68	HMO	90	TCM Developmental Disability
18	Ophthalmology	40	Hand Surgery	69	MHO	91	TCM Children at Risk
19	Oral Surgery	47	Psychology	70	Clinic/Other	92	Nurse Practitioner
20	Orthopedic Surgery	48	Podiatry	71	Ambulatory Surgery Center	99	Unknown
21	Pathologic Anatomy	50	Certified Nurse Specialist	72	Diagnostic Clinic		
22	Pathology	51	Physician Assistant	73	Public Health Clinic		

Table 4

Please find the provider type that you indicated in Question 5 to determine which certification/license requirements must accompany your enrollment.

Provider Type	Certification/License Required
01 – Inpatient/Outpatient Hospital	Worksheets A, A8, C, Part 1 and G2 most recent Medicare cost reports and license (if out-of-state hospital, cost report is not required)
02 – Outpatient Hospital Only	Worksheets A, A8, C, Part 1 and G2 most recent Medicare cost reports and license
03 – Swing Bed Hospital	License
04 – EPSDT Chiropractors	License
04 – EPSDT Respiratory Therapy	License
45 - Schools	Each school must complete an enrollment form. School psychologists must include copy of class 6 specialist license with school psych endorsement CSCT services – copy of contract btwn MHC and school must be included
05 – Podiatrists	License
06 – Physical Therapist	License
07 – Speech Therapist	License
08 – Audiology	License
09 – Hearing Aid Dispensers	License
10 – Occupational Therapists	License
12 – Personal Assistance Providers	This does not include personal care facilities. Self-directed personal assistance indicate specialty 70 on page 1
17 – Psychologists	License
18 – Dentists	License
19 – Pharmacies	License
46 – Home Infusion Therapy	License. Please indicate provider specialty 78 on page 1
21 – Optometrists	License
23 – Transportation – Common Carriers	Class B Commercial License (Taxicabs) Air Carrier Certificate (Air Charter) Business License (Travel Agency) Or Federal Highway Administration
24 – Transportation – Specialized Non-Emergency	Class B Commercial License or letter from the PSC
25 – Ambulance (Air or Ground)	License
26 – Nursing Facility	License
27 – Physician	License
28 – Home and Community Based Services	Facilities – license for personal care facility or adult foster home
29 – Targeted Case Management	Must enter specialty on page 1
35 – Nutritionist	License
38 – Residential Treatment Centers	License
40 – Independent Laboratories	CLIA Certification
42 – Social Worker	License
43 – Denturists	License
44 – Mid-level Practitioners	License. Please indicate provider specialty on page 1
44 - Physician Assistants	License
50 – Chiropractor (QMB Only)	License
52 – Free Standing Dialysis	License, Medicare Certification and copy of composite rates
53 – Home Health	License, CMS Certification and Montana Medicaid surety bond
54 – Hospice	License and CMS Certification
55 – Rural Health Clinics	License and Medicare Certification
56 – Federally Qualified Health Centers	License and Medicare Certification
58 – Licensed Professional Counselors	License
59 – Community Mental Health Clinics	Certification
60 – Targeted Case Management Mental Health Only	Certification
61 – Therapeutic Group Home	License
62 – Ambulatory Surgical Centers	License and Medicare Certification
64 – Therapeutic Foster Care	License
65 – Psychiatrist	License
72 – Independent Diagnostic Treatment Facility	Medicare Certification