GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Provider Enrollment Checklist

Provider Type – Infusion Clinic/ Agency (A2)

Specialty – Infusion Clinic/Center (704)

.

Specialty – Home Infusion Agency (108)

Enrollment Type: Group or Clinic

Application Information:

The following is an overview of the primary information needed to complete an application for the provider type and specialty listed above. Please note that all service locations where Medicaid beneficiaries are rendered services must be enrolled.

- ☐ **General information** including provider type, enrollment effective date, legal name, employer identification number (EIN), last name, first name, date of birth, social security number (SSN), national provider identifier (NPI), and contact information.
- ☐ **Specialty and taxonomy information** including effective dates.
- ☐ **Address information** including service location address of all locations at which services are rendered to Medicaid beneficiaries, mail to, and pay to addresses.
  Note: If enrolling with an enrollment type of 'Individual within a Group' service location address information is not captured.
- ☐ **Tax classification information** including organization type (e.g. non-profit, for profit).
- ☐ **Medicare enrollment** (if applicable) including Medicare number, Medicare type, effective and end dates, and other state Medicaid enrollment information (if applicable).
- ☐ **Malpractice Insurance information** (if applicable) such as type of carrier, name of carrier, coverage amount, policy number, and effective and end dates.
- ☐ **Self-disclosure information** including actions taken against or changes to your license/certification, enrollment terminations, actions taken against a federal or state controlled substance certificate, actions taken against you during participation in a governmental healthcare program, investigations, actions taken against your

professional liability coverage and contact information for audit purposes (42 CFR § 455.100-106).

- ☐ **Subcontractor disclosure information** for any entity/individual with which you have had any business transactions totaling more than $25,000 during the preceding 12-month period. If applicable, you will be required to provide subcontractor information such as name, address, effective and end dates, and control interest. If control interest is reported, additional ownership details such as % interest, name, SSN, DOB, and address will also be required (42 CFR § 455.100-106).

- ☐ **Ownership and control interest information** in the disclosing entity (individual or corporation). For entities having ownership/control interest in the disclosing entity, information such as ownership/control interest in any other provider, fiscal agent or managed care entity, criminal convictions in other government programs, other state Medicaid participation, program terminations, outstanding debts with other government programs, adverse legal actions, and relationships to the entity having ownership/control interest in the provider will be required (42 CFR § 455.100-106).
  Note: A person with an ownership or control interest means a person or corporation that has a direct or indirect ownership totaling 5% or more in the provider, is an officer or director of a provider organized as a corporation or non-profit or is a partner in a provider organized as a partnership.

- ☐ **Managing employee information** such as name, SSN, DOB, address, email, effective and end dates, criminal convictions in other government programs, other state Medicaid participation, program terminations, outstanding debts with other government programs, adverse legal actions, and relationship to the provider (42 CFR § 455.100-106).
  Note: One form must be completed for each managing employee. Per 42 CFR § 455.101, a managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

- ☐ **Business transactions** with any wholly-owned supplier or subcontractor. Information required includes name, tax ID, DOB (for individuals), effective and end dates, and address (42 CFR § 455.105).
  Note: One form must be completed for each wholly-owned supplier or subcontractor.

- ☐ **Application fee** will be required if you have not already paid the fee to Medicare or another state's Medicaid program (42 CFR § 455.460).
  Note: You can upload proof of payment as an attachment to your application if you have already paid the fee to Medicare or another state's Medicaid program. Proof of payment is a receipt or formal notification from Medicare or another state Medicaid program specifically indicating payment of the application fee.

Required Documents:

The following is a list of required enrollment documents for the provider type and specialty listed at the beginning of this document. A copy of each document listed below must be uploaded with

your online application to the Provider Enrollment Portal (PEP). Exceptions to the required documents are noted as applicable.

- ☐ Documentation showing taxpayer identification number (TIN) (signed W-9)
- ☐ Current professional license indicating the license number, issue date, and expiration date
- ☐ Current Malpractice/liability insurance
  Note: If you carry malpractice or liability insurance, please provide a copy.

You do not need to submit this checklist with your enrollment/revalidation documents.

If you have questions regarding your enrollment in the Puerto Rico Medicaid Program (PRMP), please submit your inquiry by email to prmp-pep@salud.pr.gov.