STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

21st Century Cures Act Application for Individual NJ FamilyCare Health Plan Providers

Application package consists of:

1. Application Cover Letter
2. Provider Application - FD-20D (Rev. 05/16/2023)
3. Provider Agreement - FD-62
4. Notice to Enrollee (documentation required) - FD-462
5. Affirmative Action Survey (optional) - FD-450
6. Agreement of Understanding - FD-435

If you are an individual provider, and a Social Security Number is the primary means of identity, you may be requested to submit a copy of your Social Security Card.

If all components are present and complete, the 21st Century Cures Act applicant may be approved for participation by Gainwell Technologies. The effective date of approval will be the date of the Provider Agreement.

You must attach a copy of all current License(s), Registration(s) and Board Certification(s) and complete the conviction/exclusion information and the provider certification on Page 4

Application Cover Letter

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Dear Provider:

Your request for a Provider Specific Enrollment Packet has been received and documented. We are mailing you the packet of forms needed to meet enrollment requirements for your provider type. Please complete the forms and make sure all questions are answered; where not applicable, just enter N/A. Otherwise, there will be a delay in the enrollment process.

Other attachments required for your provider type are listed on the preceding page.

Your promptly completed enrollment packet will ensure a speedy enrollment process. If you have not received any correspondence within a month, please write to:

Provider Enrollment
Gainwell Technologies
P.O. Box 4804
Trenton, NJ 08650

Provider Enrollment Unit
609-588-6036

For Fiscal Agent Internal Use Only

Provider Name: _____

Doc Type: _____ Provider Type: _____ Provider Specialty: _____

NPI Number: _____ Social Security No.: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

21st Century Cures Act Application for Individual NJ FamilyCare Health Plan Providers

Legal Name: _____ **DBA Name:** _____

Date of Birth: _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Contact Name: _____ **Contact Phone #:** _____

Email Address: _____ **Fax Number:** _____

Type of Service: _____ **SS #:** _____ **Tax ID:** _____

Taxonomy Code: _____ **(if available)**

to determine specialty

IF APPLICABLE, APPLICANTS MUST REPORT THE FOLLOWING INFORMATION

NPI Number: _____ must be type 1 (individual) npi only

***IMPORTANT NOTE: The NPI reported should match the NPI reported to the Managed Care Organization.**

Medicaid Provider No.: _____ **State:** _____

Medicare Provider No.: _____ **Lab-CLIA No.:** _____

Medical Professional License No.: _____ **State of Licensure:** _____

Federal DEA Registration No.: _____ required for Pharmacy

Certification No.: _____ **Type:** _____ **Certifying Entity:** _____

State of Certification: _____

NJDCA Home Improvement Registration No.: _____

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You must attach a copy of all current License(s), Registration(s) and Board Certification(s) and complete the conviction/exclusion information and the provider certification on Page 4

Applicants completing this application are under no obligation to accept NJ FamilyCare (NJFC) fee-for-service (FFS) beneficiaries into their professional practice.

In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title.

Applicants approved as 21st Century Cures Act providers are not authorized to bill or receive NJFC FFS reimbursement from the State of New Jersey. However, providers may submit a full FFS application to receive such authorization if they so choose.

21st Century Cures Act providers are required to comply with all applicable State and federal laws, rules and regulations in regard to providing a healthcare service(s) to a NJFC beneficiary.

Final Adverse Actions /Convictions

The section below defines the convictions and final adverse actions that must be reported in this application regardless of whether any records were expunged or any appeals are pending.

Convictions:

1. Within the last 10 years preceding this application for enrollment or revalidation of enrollment, conviction for 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 or NJFC 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.

21st Century Cures Act Application for NJ FamilyCare Health Plan Providers (Continued)

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 of 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 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 Identification Number.

5. Any Medicare revocation of any Medicare Identification Number.

Have you, under any current or former name or business identity, ever had any final adverse legal action(s) listed above under **Convictions, Exclusions**, **Revocations, or Suspensions** in this application, imposed against you? Yes ☐ No ☐

If yes, on a separate sheet of paper 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.

21st Century Cures Act Application for NJ FamilyCare Health Plan Providers (Continued)

Provider's Certification:

Do you, under any current or former business identity, have uncollected debt, are or have been subject to payment suspension under a Federal health care program, or have had your billing privileges denied or revoked?

Yes ☐ No ☐ **(If YES, attach a detailed explanation)**

Have you, under any current or former business identity, have a current or former affiliation (directly or indirectly) with a provider of medical or other items or services or supplies, that has uncollected debt, has been or is subject to payment suspension under a Federal health care program, or has had its billing privileges denied or revoked?

Yes ☐ No ☐ **(If YES, attach a detailed explanation)**

I certify that the foregoing information provided in this application is true, accurate and complete and I also acknowledge that I understand that providing any false statement, or false document, or concealing any material facts may subject me to penalties and/or prosecution under applicable federal or state laws.

Also, by signing this application, I consent to a civil and criminal background check by DMAHS and/or by the Medicaid Fraud Division of the Office of the State Comptroller. I understand that if the results of this background check are unsatisfactory, the Division of Medical Assistance and Health Services may refuse an applicant's participation in the NJFC FFS program and the applicant's provider contract with the health plan may be terminated.

does not require Wet Signature

Provider's Signature Original Signature Required - No Stamps	Print Name	Date
Signature of Person Completing Form	Print Name	Date

Thank you for taking the time to enroll as a 21st Century Cures Act provider in the NJFC program as required by Federal regulations. Please mail the signed application with required documentation to:

Gainwell Technologies Provider Enrollment
P.O. Box 4804
Trenton, NJ 08650

You can also fax the completed application with credentials to: 609-584-1192.

If you have any questions, Gainwell Technologies Provider Enrollment can be reached at 609-588-6036.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

PROVIDER NAME

PROVIDER AGREES:

1. To comply with all applicable State and Federal laws, policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish the DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Sections of both the Division of Criminal Justice and the State's Comptroller Office with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 2428 which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.107.

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c., or otherwise permitted or required by State or Federal Law.

The provider or DMAHS may, on 60 days written notice to the other party, terminate this Agreement without cause.

Does not require wet signature to be mailed

DATE

SIGNATURE OF PROVIDER

PRINT NAME AND TITLE

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

Notice to Enrollee(s)

In an effort to properly set-up the identity of an individual or an entity as a NJ Medicaid provider the Division requires that when a social security number is the primary means of identity you may be requested to submit a copy of your social card.

If you are an entity, you are required to submit a copy of your 147C letter from the IRS or copy of the IRS CP-575 form.

PLEASE BE ADVISED THAT YOUR APPLICATION TO BECOME A NJ MEDICAID PROVIDER CANNOT BE COMPLETED UNTIL WE HAVE RECEIVED A COPY OF THESE DOCUMENTS.

AFFIRMATIVE ACTION SURVEY (OPTIONAL)

Dear Provider:

The Department of Human Services, Division of Medical Assistance and Health Services, which administers the New Jersey Medicaid Program, is conducting an Affirmative Action Survey of its participating providers.

This survey is being used as a tool to better understand the diversity of our provider network and the needs of our clients. The completion of this survey is voluntary. The statistical data from this survey will be used for Affirmative Action purposes only and will be maintained separately from all other types of information.

Please refer to definitions below and check or fill in appropriate responses in space indicated:

From N.J.A.C. 4A:7-1.1(D):

"White, Not of Hispanic Origin"	Means persons having origins in any of the original Peoples of Europe, North Africa or the Middle East
"Black, not of Hispanic Origin"	Means persons having origins in any of the Black Racial Groups of Africa
"Hispanic"	Means persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish Culture or origin, regardless of race.
"American Indian or Alaskan Native"	Means persons having origins in any of the original Peoples of North America, and who Maintain cultural identification through Tribal Affiliation Community Recognition.
"Asian or Pacific Islander"	Means persons having origins in any of the original Peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

1. How many direct service providers are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

2. How many of your support staff are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

3. How many of service provider(s) speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____
_____ _____
_____ _____

4. How many of the support staff speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____
_____ _____
_____ _____

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

*Agreement of Understanding

To the Person Submitting this Enrollment Packet:

I understand that upon receipt of this enrollment packet to Gainwell Technologies, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA see NJSA Section 47:1A).

Before any documents are sent to someone requesting this information, all personal information such as tax Id and social security numbers would be redacted.

It is the responsibility of the person signing this Agreement of Understanding to convey this information to all of individuals who are named in this application to become a New Jersey Medicaid provider. Although the request for enrollment information is uncommon, it does fall under the Open Public Records Act.

I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey.

_____

Sign

_____

Print

May be provider or person completing the app

_____

Date

*A signed Agreement of Understanding is required before an application can be processed.

09/12/2023

Federal Regulations and NJSA Code Quoted in Provider Agreement

N.J. Stat. § 30:4D-6.c.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.