

**ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP
APPLICATION CHECK LIST
UPDATED: MAY 2024**

- If applicable, have you contacted Managed Care Operations (MCO):** If you are completing this agreement for a new enrollment that resulted in being issued a new Medicaid Billing Group ID, you must contact the MCO Division at Medicaid for additional processing. Failure to contact MCO may result in omitted attribution for the new Medicaid Billing Group ID. You may contact MCO at ACHN@medicaid.alabama.gov.

- Ensure that you are using the most current application that is listed on the Medicaid Agency’s website. ALL pages must be from the current application on the website. There will be a revised date at the bottom right-hand corner of the application (as shown below).**

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

**Alabama Medicaid
Primary Care Physician Group
Enrollment Agreement**



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Forms should be submitted electronically to:
Gainwell Technologies using the Alabama Medicaid Web Portal

If you are completing this agreement for a new enrollment that resulted in being issued a new Medicaid Billing Group ID, you must contact the Managed Care Operations (MCO) Division at Medicaid for additional processing. Failure to contact MCO may result in omitted attribution for the new Medicaid Billing Group ID. You may contact MCO at ACHN@medicaid.alabama.gov.

The enrollment effective date for this agreement will be the first day of the following month if the agreement is received and contains no errors prior to the 15th of the month. Otherwise, the effective date of the agreement will be the month following the next month.

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- Ensure that you have selected “YES” for intent to participate in the Alabama Coordinated Health Network (ACHN) Program.** You must select at least one ACHN Entity from the listing (i.e. *My Care Alabama Northwest, North Alabama Community Care, Alabama Care Network-Midstate, My Care Alabama Central, My Care Alabama East, Alabama Care Network Southeast, or Gulf Coast Total Care*).

- Ensure that you have answered question, “Has this practice or anyone associated with this practice been terminated or sanctioned by Medicare or Medicaid?”**

- Ensure that you have answered question, “Are you associated with an academic teaching facility?”**

- Ensure that you have selected the appropriate SPECIALTY type for your GROUP:** You will need to select the specialty that your group is currently enrolled as with Alabama Medicaid. You may select “Other” and enter a non-listed provider type (non-listed provider type enrollments must meet ACHN criteria and be approved by Medicaid). Please contact Provider Enrollment if assistance is needed with determining your specialty type.

- Ensure that you have indicated your GROUP/CLINIC NAME:** You will need to indicate the same name that your group is currently enrolled as with Alabama Medicaid.

- Ensure that you have indicated your MEDICAID GROUP ID:** Your Medicaid Group ID is different from your NPI number and is unique for Alabama Medicaid Providers. The Medicaid Group Billing ID can be found on your Alabama Medicaid Financial Remittance Advice (RA) or your Alabama Medicaid Welcome Letter. If further assistance is needed with determining your Medicaid Group Billing ID, please contact Provider Enrollment at 1-888-223-3630.

- Ensure that you have indicated your GROUP NPI:** Your NPI is different from your Medicaid Group ID. Your Group NPI is issued by CMS.

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- Ensure that you have indicated your **GROUP TAX ID**: Your Group TAX ID is issued by the IRS.
 - Ensure that you have indicated your PHYSICAL ADDRESS (PRIMARY LOCATION)**: You will need to indicate the same physical address that your group is **currently** enrolled as with Alabama Medicaid.
 - Ensure that you have indicated your **MAILING ADDRESS**: This address will be used for all mail correspondence for the group. If this area is not complete, we will use the physical address listed for the mailing address.
- NOTE:** The mailing address indicated above will be applied to the file of the provider for which this application is completed.
- Ensure that you have indicated your CREDENTIALING CONTACT NAME/TELEPHONE NUMBER/EMAIL ADDRESS**: This will be the person that will be contacted if there are issues with enrollment.

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- Ensure that you have indicated ALL Primary Care Physician’s that intend to participate with the ACHN and are enrolled under your group.**
Note: The provider must be currently enrolled **AND** active with Alabama Medicaid. Pending enrollments should **NOT** be listed on the application.
- The participating PCPs **must** be listed under the *physician* section on page 3 (see highlighted area below).

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

List the Physicians and Physician Collaborators that are associated with this Agreement. Physician Collaborators must be linked to the same Group Enrollment NPI as the oversight physician. A Physician Collaborator is a Physician Assistant or Nurse Practitioner that practices under the collaboration of a licensed physician.

<small>Physician Name</small>	<small>Medicaid Provider ID</small>
<small>Physician Collaborator</small>	<small>Medicaid Provider ID</small>

A change in the Medicaid Provider ID will require an additional Medicaid application. If you have questions, please call Gainwell Provider Enrollment Department at 1-888-223-3630.

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- **Provide ALL the PHYSICIAN’S NAMES & the MEDICAID PROVIDER IDs (not NPI)** that were issued by the Alabama Medicaid Agency.
 - The provider must be enrolled with the Group that is applying for ACHN enrollment. The provider must be enrolled under the same TAX ID and NPI as the Group that is applying for ACHN enrollment.
- Ensure that you have listed all mid-levels (nurse practitioners & physician assistants) under the section titled “physician collaborators.”** A Physician Collaborator is a Physician Assistant or Nurse Practitioner that practices under the collaboration of a licensed physician. **Also list their MEDICAID PROVIDER IDs (not NPI)** that were issued by the Alabama Medicaid Agency.
NOTE: The physician collaborator must be currently enrolled **AND** active with Alabama Medicaid. Pending enrollments should **NOT** be listed on the application.
- The physician collaborators **must** be listed under the *physician collaborator* section on page 3 (see highlighted area below).

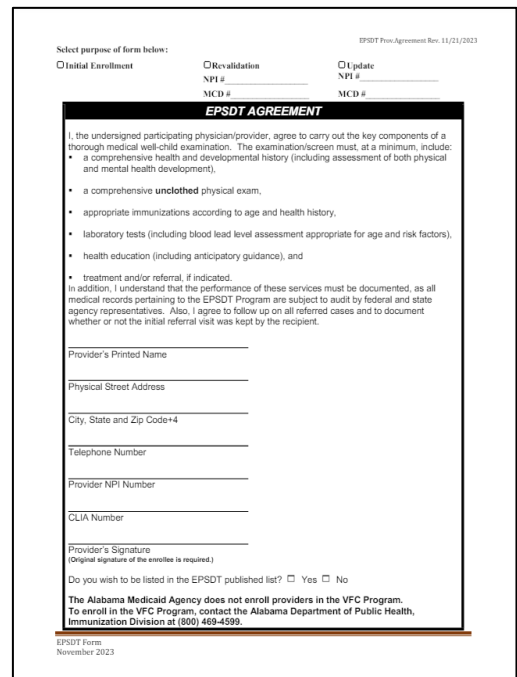
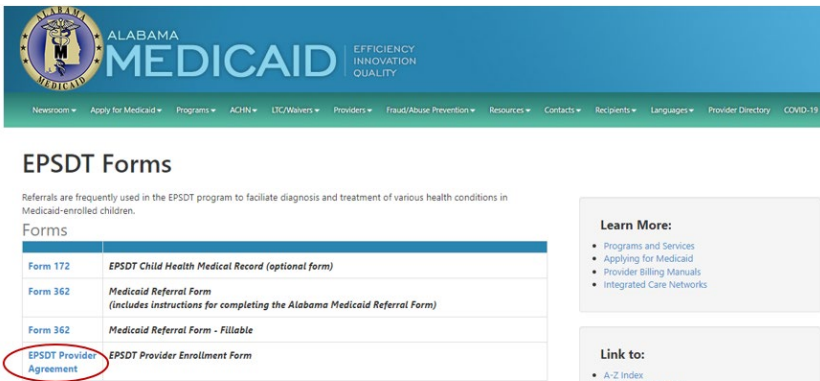
ALABAMA MEDICAID PRIMARY CARE PHYSICIAN GROUP APPLICATION CHECK LIST **UPDATED: MAY 2024**

EPSDT

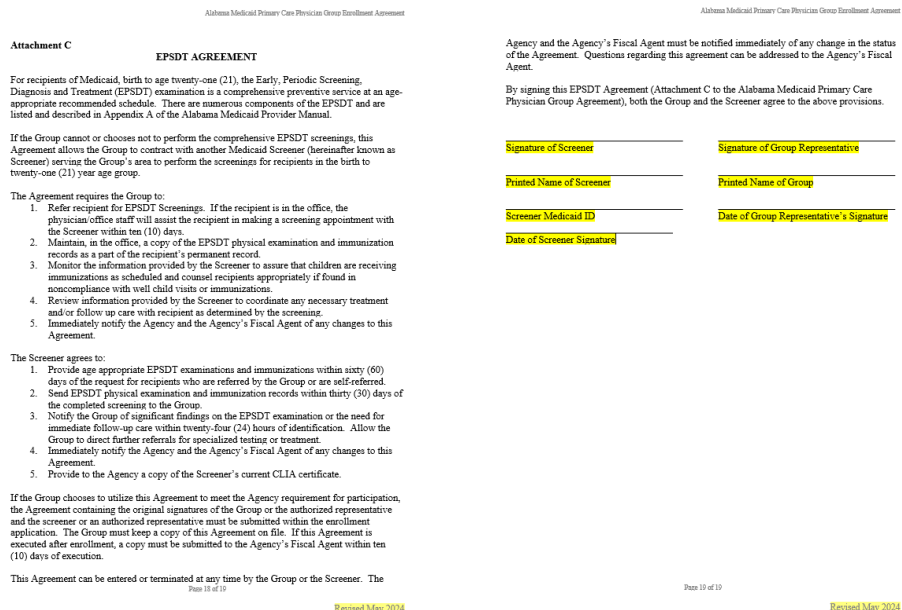
Ensure that you have answered and completed the **EPSDT** section.

Note: If you only see adult patients (ages 21 and older), EPSDT enrollment is not required. You will need to submit a signed letter on your company's letterhead informing the Alabama Medicaid Agency that you only accept adult patients and would not like to enroll in EPSDT.

- Are you currently enrolled in the EPSDT program?
 - If you select **YES**, no other action is required. The Alabama Medicaid Agency will verify that you are currently enrolled with EPSDT.
 - If you select **NO**, you **must** answer the following question on the application: **If you are not currently enrolled, will you be doing your own EPSDT screenings?**
 - If you select **YES to the question above**, you must complete and sign an EPSDT agreement and submit a copy of your current CLIA certificate. The EPSDT agreement can be accessed from the Medicaid Agency's website with the following link: [https://www.medicaid.alabama.gov/content/9.0 Resources/9.4 Forms Library/9.4.5 EPSDT Forms.aspx](https://www.medicaid.alabama.gov/content/9.0%20Resources/9.4%20Forms%20Library/9.4.5%20EPSDT%20Forms.aspx)
(Please note the EPSDT Agreement is different from the Attachment C form in this application. You must access the EPSDT Agreement from the website if you would like to enroll as an EPSDT provider. See below).



- If you select **NO** to the question above, you must designate an EPSDT enrolled provider to conduct your screenings for you. The provider you designate to conduct your EPSDT screenings **must** complete and sign Attachment C of the application. Attachment C can be found on pages 18-19 of the application (see below).



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24 Hours/7 Days Telephone Coverage: Complete Attachment A (page 15)

Ensure that you have answered and completed the *24 Hours/7 Days Telephone Coverage* section.

- Ensure that you have indicated a telephone number where patients can reach you outside of your normal business hours.
- The telephone number can be an answering service or a voicemail. In either situation, the patient must be contacted within one (1) hour. Advising patients to go to the emergency room is **NOT** acceptable.
- Ensure you answer Yes or No to the question: “Will the group comply with below requirements as outlined in Attachment A?”
- Ensure you answer Yes or No to the question: If yes, will the group return the recipients’ calls within one (1) hour as agreed?
- Ensure that Attachment A (page 15) is completed and signed. **ATTACHMENT A IS REQUIRED WITH ALL APPLICATIONS** (see below).

<p style="text-align: center;"><small>Alabama Medicaid Primary Care Physician Group Enrollment Agreement</small></p> <p>Attachment A</p> <p style="text-align: center;">ALABAMA MEDICAID AGENCY PRIMARY CARE PHYSICIAN GROUP 24/7 VOICE-TO-VOICE COVERAGE AGREEMENT</p> <p><small>Primary Care Physician Group (Group) must provide recipient with after-hours voice to voice coverage. It is essential that recipients and/or other providers are able to contact the Group to receive instructions for care or referrals at all times to ensure that care is provided in the most appropriate manner related to the recipient's condition. To satisfy the after-hours voice-to-voice coverage requirement, the Group must meet one of the following requirements:</small></p> <ol style="list-style-type: none">1. The after-hours telephone number must connect the recipient to the Group or an authorized medical practitioner.2. The after-hours telephone number must connect the recipient to a live voice, answering service, or a medical practitioner on-call for the physician or Group. In the event that a recipient must leave a message or their call is handled by an answering service, the recipient must receive a call back, with instructions from the Group or Group's authorized medical practitioner, within one (1) hour of the initial contact. <p><small>A Group's office telephone line that is not answered after hours or answered after hours by a recorded message instructing recipients to call back during office hours or to go to the emergency department for care is not acceptable.</small></p> <p><small>The after-hours coverage requirement will be monitored regularly. If during the monitoring process a provider is not meeting the requirements as stated above, the following will occur:</small></p> <ol style="list-style-type: none">1. The Group will be contacted in writing and asked to submit within ten (10) business days of receipt of the letter, a corrective action plan (CAP) describing what steps will be taken to comply with the requirements).2. The Group will receive a follow-up monitoring call within thirty (30) calendar days following submission of a CAP to determine implementation of the CAP and continuing compliance. If after the follow-up monitoring call, the Group is not maintaining compliance with the requirement, the Group will be notified in writing of the non-compliance status and will be placed on suspension from the ACHN until further notice. Suspension from participating with the ACHN will result in not receiving bonus payments and/or ACHN Participation Rates. Notification of the suspension status will be forwarded to the Agency's Chief Medical Officer.3. If the Group fails to submit a CAP within the allotted time, the Group will be notified in writing of the non-compliance status with the Agreement and will be placed on suspension until further notice. The Group will be asked to submit a CAP within five (5) business days of receipt of the letter. <p style="text-align: right;"><small>Page 14 of 19</small></p> <p style="text-align: right;"><small>Revised May 2024</small></p>	<p style="text-align: center;"><small>Alabama Medicaid Primary Care Physician Group Enrollment Agreement</small></p> <ol style="list-style-type: none">a. If the CAP is received in the allotted time and approved, the Group will be reinstated.b. If the Group fails to submit a CAP within the allotted time, the Group will be notified by certified mail of failure to comply with the after-hours coverage requirements and as a result has failed to comply with the Alabama Medicaid Primary Care Physician Group Agreement and the Agreement will be terminated. <p><small>Printed Group Name</small> _____ <small>Signature of Group Representative</small> _____</p> <p><small>Date of Signature</small> _____ <small>Group Medicaid ID</small> _____</p> <p style="text-align: right;"><small>Page 15 of 19</small></p> <p style="text-align: right;"><small>Revised May 2024</small></p>
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Ensure that you have indicated your Group’s name at the top of page 5 of the *Alabama Medicaid Primary Care Physician Group Agreement*.

Ensure that you have read and understand the entire agreement (pages 5-13).

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Note: The enrollment **effective date** for the ACHN PCP Group Agreement will be the first day of the following month, if the agreement is received and contains no errors prior to the 15th of the month. For agreements received on or after the 15th of the month, the effective date of the enrollment will be the month following the next month. **(Refer to Provider Manual 40.3.1)**

Ensure that you have indicated an **effective date** on page 13.

(PAGE 13)- Alabama Medicaid Primary Care Physician Group Agreement (signature page)

Ensure that page 13 is completed accurately. See below for instructions on completing page 13.

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Alabama Medicaid Primary Care Physician Group Enrollment Agreement


A. In the event that state or federal funds that have been allocated to the Agency are eliminated or reduced to such an extent that, in the sole determination of the Agency, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from the Agency;

B. If the approved Alabama State Plan is discontinued either by the Agency or CMS;

C. If the Group is determined to be in violation of terms of this Agreement, or applicable federal and state laws, regulations, and policy, or fails to maintain program certification or licensure;

D. Upon the sale of the Group's practice, or termination of participation as a Medicaid or Medicare provider; or

E. In the event of conduct by the Group justifying termination, including but not limited to breach of confidentiality or any other covenant in this Agreement, and/or failure to perform designated services for any reason.

XII. Effective Date and Duration 

This Agreement shall be effective _____ or the first day of the month in which this Agreement is fully executed pursuant to the terms of this Agreement and remain in effect until amended or terminated.

<p style="color: red; font-size: small;">Print Group's Name on this line</p> <p>Printed Name of Group _____</p> <p style="color: red; font-size: small;">Sign (cursive) Group Representative's Name on this line</p> <p>Signature of Group Representative _____</p> <p style="color: red; font-size: small;">Print the Group's NPI on this line. / Print the Group's Medicaid ID on this line.</p> <p>Group NPI and Medicaid ID Number _____</p> <p style="color: red; font-size: small;">Print the date that the application was signed on this line.</p> <p>Date of Group Representative's Signature _____</p>	<p style="color: red; font-size: small;">Nothing goes here. (Agency's use ONLY)</p> <p>Alabama Medicaid Agency _____</p> <p style="color: red; font-size: small;">Nothing goes here. (Agency's use ONLY)</p> <p>Signature of Agency Representative _____</p> <p style="color: red; font-size: small;">Nothing goes here. (Agency's use ONLY)</p> <p>Date of Agency Representative's Signature _____</p>
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(PAGE 15) Attachment A (signature page) 24/7 Coverage Agreement

Ensure that page 15 is completed accurately. See below for instructions on completing page 15.

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

a. If the CAP is received in the allotted time and approved, the Group will be reinstated.

b. If the Group fails to submit a CAP within the allotted time, the Group will be notified by certified mail of failure to comply with the after-hours coverage requirements and as a result has failed to comply with the Alabama Medicaid Primary Care Physician Group Agreement and the Agreement will be terminated.

<p style="color: red; font-size: small;">Print Group's (or Group Representative's) Name on this line</p> <p>Printed Group Name _____</p> <p style="color: red; font-size: small;">Print the date that the application was signed on this line</p> <p>Date of Signature _____</p>	<p style="color: red; font-size: small;">Sign (cursive) Group's (or Group Representative's) Name on this line</p> <p>Signature of Group Representative _____</p> <p style="color: red; font-size: small;">Print the Group's Medicaid ID (not NPI) on this line</p> <p>Group Medicaid ID _____</p>
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(PAGE 17) Attachment B (signature page) Hospital Admitting Agreement

Ensure that page 17 is completed accurately. See below for instructions on completing page 17.

Note: page 17 (Attachment B- Hospital Admitting Agreement) is only required if you are designating another Group/Physician to admit patients to a hospital on your behalf. This page **must** be completed by the Group/Physician that you have designated to admit patients on your behalf.

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Group Agreeing to Cover Hospital Admissions:

PRINT Group's/Physician's Name on this line (The name of the Group/Physician that will be admitting patients on your behalf) PRINT Group's/Physician's Medicaid ID (not NPI) on this line (The Medicaid ID of the Group/Physician that will be admitting patients on your behalf)

Group Name: _____ Group ID: _____

Mailing Address: _____
 PRINT Group's Mailing Address on this line (The mailing address of the Group/Physician that will be admitting patients on your behalf)

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____
 PRINT the hospital that the Group will admit patients to on this line (This should be the name and address of the hospital the Group/Physician that will be admitting patients on your behalf)

Contact Person: _____ Number: () _____
 Sign (cursive) name of the physician that will be admitting patients on your behalf Print the date that the application was signed on this line

Authorized Signature: _____ Date: _____

PRINT Group's Specialty on this line (The specialty of the Group/Physician that will be admitting patients on your behalf)

PRINT Group's age range on this line (The age range of the Group/Physician that will be admitting patients on your behalf)

PRINT the contact person and their telephone number on these lines (This should be the contact person and telephone number for the Group/Physician that will be admitting patients on your behalf)

(PAGE 19) Attachment C (signature page) EPSDT Agreement

Ensure that page 19 is completed accurately. See below for instructions on completing page 19.

Note: page 19 (Attachment C- EPSDT Agreement) is only required if you are designating another Group/Physician to complete EPSDT screenings for recipients under the age of 21. This page **must** be completed by the Group/Physician that you have designated to complete EPSDT screenings on your behalf.

Alabama Medicaid Primary Care Physician Group Enrollment Agreement

Agency and the Agency's Fiscal Agent must be notified immediately of any change in the status of the Agreement. Questions regarding this agreement can be addressed to the Agency's Fiscal Agent.

By signing this EPSDT Agreement (Attachment C to the Alabama Medicaid Primary Care Physician Group Agreement), both the Group and the Screener agree to the above provisions.

Sign (cursive) name of the physician that will be completing EPSDT screenings on your behalf. Sign (cursive) name of the EPSDT screener's Group or Group Representative of that will be completing EPSDT screenings on your behalf.

Signature of Screener **Signature of Group Representative**

Print name of the physician that will be completing EPSDT screenings on your behalf. Print name of the EPSDT screener's Group or Group Representative of that will be completing EPSDT screenings on your behalf.

Printed Name of Screener **Printed Name of Group**

Print Medicaid Provider ID (not NPI) of the physician that will be completing EPSDT screenings on your behalf. Print the date the Group or Group Representative that will be completing EPSDT screenings on your behalf signed the agreement.

Screener Medicaid ID **Date of Group Representative's Signature**

Print the date the physician that will be completing EPSDT screenings on your behalf signed the agreement. _____

Date of Screener Signature

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